Report to Residents of the Northwest Territories on Comparable Health and Health System Indicators

This report is consistent with the Federal/Provincial/Territorial agreement by Ministers of Health to report on comparable health indicators

Northwest Territories Health and Social Services

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Minister's Message

I am pleased to present the *2002 Report to Residents of the NWT on Comparable Health and Health System Indicators*. This report honours the September 2000 commitment made by all First Ministers to provide regular reporting on a set of common indicators for health status, health outcomes and quality of service.

This report builds on our own government's commitment to ensure high quality information is readily available to the NWT public, government decision makers and health care practitioners. For example, the *1999 Health Status Report* and *2000 Health Services Report* provide a more detailed look at health status and service provision in the NWT. These reports will be produced every three years to ensure that information is current for setting priorities for service delivery.

The *2002 Report to Residents* highlights issues that are familiar to us. We have high rates of communicable diseases and injuries compared to national statistics, and our higher rates of lung cancer reflect our higher rates of smoking. And there are other issues that are of great concern to the NWT, like addictions and family violence, which are not included in this report as these topics were outside the scope of this initiative.

This report also presents a brief overview of service quality and level of public satisfaction with NWT health services. When residents were polled during 2000-2001, the majority expressed their satisfaction with services provided in their communities as well as in hospitals and by physicians - this in spite of staffing shortages in health care professions. Staffing shortages continue to be a challenge nation-wide, and particularly here in the NWT, and the public has expressed concern about quality of service delivery as a result of these shortages. The Government of the NWT remains committed to addressing these shortages so that the public continues to have confidence in the services we provide.

The baseline information presented in this report contributes to our overall understanding of the pressures on our system, both from a health status and operational perspective. It is equally important that we continue to participate in cross-country reporting initiatives such as this so that we have a nation-wide profile of statistics to provide context to these issues.

J. Michael Miltenberger
Minister of Health and Social Services

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Executive Summary

This is the first *Report to Residents of the Northwest Territories on Comparable Health and Health System Indicators*. The report's purpose is to fulfill a commitment made by the federal/provincial/territorial (FPT) First Ministers to provide clear accountability reporting to Canadians. The First Ministers directed their Ministers of Health to develop a set of indicators that could be used to provide comprehensive and regular public reporting on health status, health outcomes and quality of service.

The FPT Ministers of Health established the Performance Indicators Reporting Committee (PIRC) to develop a common set of indicators in the following 14 areas:

Health Status

1 Life expectancy
2 Infant mortality
3 Low birth weight
4 Self-reported health

Health Outcomes

5 Change in life expectancy
6 Improved quality of life
7 Reduced burden of disease, illness and injury

Quality of Service

8 Waiting times for key diagnostic and treatment services
9 Patient satisfaction
10 Hospital re-admission for selected conditions
11 Access to 24/7 first contact health services
12 Home and community care services
13 Public health surveillance and protection
14 Health promotion and disease prevention

The **health status** indicators are meant to reflect the overall health of the population in the NWT, while the **health outcomes** indicators are intended to reflect the impact of the health system on population health and well being. The **quality of service** indicators offer a perspective on several aspects of the quality of services available to the population.

Highlights

Life expectancy at birth in NWT was an average of 76.2 years between 1997-99, with life expectancy for women being about six years longer than for men. Disability-free life expectancy at age 65 was 10.4 years in the NWT in 1996, compared to 11.7 years for Canada.

Overall, 54% of the population age 12 or older rated their health as excellent or very good in 2000-01, but only 18% of elders gave their health an excellent or very good rating.

A 2000-01 survey found that 93.1% of NWT residents were very satisfied or somewhat satisfied with hospital services compared to 79.5% of Canadian residents.

Between 1997 and 1999, the average rate of death due to lung cancer was 70.9 deaths per 100,000 for the NWT compared to 49.3 deaths per 100,000 for Canada.

Between 2000 and 2002, the forecasted rate for prostate cancer is predicted to average 53.6 cases per 100,000 for the NWT, compared to 118.2 cases per 100,000 for Canada.

Between 2000 and 2002, the forecasted rate for colorectal cancer is predicted to average 81.1 cases per 100,000 for the NWT, compared to 49.5 cases per 100,000 for Canada.

Between 1997 and 1999, the average rate of potential years of life lost due to unintentional injuries was 1,309.2 per 100,000 compared to 696.6 per 100,000 for Canada.

After peaking at an average of 68.7 cases per 100,000 population between 1994-96, the incidence of tuberculosis dropped to an average 26.4 cases per 100,000 between 1999-01. This compares to the average of 23.5 cases observed between 1991-93. However, the incidence of chlamydia (a common sexually transmitted disease) averaged 1,166.8 cases per 100,000 population between 1999-01, compared to an average of 1,049.2 cases per 100,000 observed between 1991-93.

In 2000-01 almost 40% of the population age 20 and older reported being exposed to environmental tobacco smoke, and almost 45 % of the population between the ages of 12 and 19 were reported to be exposed to environmental tobacco smoke. In 2000-01 34.5% of 12-19 year olds reported being current smokers, with 19.3% smoking on a daily basis.

A 2000-01 survey found that a significant proportion of the NWT population was obese: 17.3% age 20-34, 20.9% age 35 to 44, and 31.2% age 45 to 64. This compared to the following national proportions of obese people: 11.3% for those age 20 to 34, 14.7% for those age 35 to 44, and 18.2% for those age 45 to 64.

These observations, and the many others made in the report, offer a perspective on the health of the people of the NWT, and on the state of their health care services. Whenever possible, comparative national data are also presented. However, the reader is cautioned about drawing too many conclusions from the data presented, for the following reasons.

The relatively small size of the population in the NWT makes it difficult to draw valid comparison to other jurisdictions with much larger populations, although this can be somewhat overcome by presenting rates in a standardized fashion (e.g., per 100,000 population). Beyond the challenges presented by population size and relatively small numbers of cases, the NWT data only go back as far as 1990 (earlier data exist, but are combined with Nunavut). As a result, trends over time remain difficult to detect.

It is the intent to prepare a report similar to the present one every two years. This will ensure that the people of the NWT are kept informed of the health status of the population, and of the outcomes and effectiveness of the health care system.

Introduction

In September 2000, First Ministers issued a Communique on Health in which they agreed to provide clear accountability reporting to Canadians. First Ministers directed Ministers of Health to provide comprehensive and regular public reporting and to develop a comprehensive framework using comparable indicators on health status, health outcomes and quality of service. All of the indicators in this report have been agreed to by the federal/provincial/ territorial (FPT) Ministers of Health and are reported according to requirements set out by the Performance Indicators Reporting Committee.[1] A key goal of this report is to be comparable to reports released by the other provincial and territorial jurisdictions. The 2002 report is the first report for all jurisdictions to present these indicators. This report examines 14 indicator sets, divided into three sections: health status, health outcome and quality of service.

Health Status
1 Life expectancy
2 Infant mortality
3 Low birth weight
4 Self-reported health

Health Outcomes
5 Change in life expectancy
6 Improved quality of life
7 Reduced burden of disease, illness and injury

Quality of Service
8 Waiting times for key diagnostic and treatment services
9 Patient satisfaction
10 Hospital re-admission for selected conditions
11 Access to 24/7 first contact health services
12 Home and community care services
13 Public health surveillance and protection
14 Health promotion and disease prevention

A description of each indicator is provided; often this information is taken verbatim from the *Plan for FPT Reporting on 14 Indicator Areas*[2].

Following the indicator's description, the results for the Northwest Territories (NWT) are presented. Where possible, a time trend has been provided, but in some cases only a single year of data was available. Where appropriate, single years of data have been combined into averages of three or more years, often referred to as rolling averages (i.e., 1991 to 1993, 1992 to 1994, and so on.) These rolling averages are used to minimize the year-to-year variability associated with small numbers. In addition, an annual average of all years of data available is provided with some indicators.

Four appendices follow the presentation of data. Appendix A provides a copy of the First Ministers' Communique on Health. Appendix B provides a set of tables with the raw data on most indicators and Appendix C provides details on methodology and data sources. Appendix D provides the Auditor General's Report.

The reader should become familiar with the following three concepts used regularly throughout the report.

1. Population-based Rates
Much of the data is presented as population-based rates. Population-based rates allow for comparisons between populations of different sizes. A population-based rate takes an indicator, such as the number of cancer deaths,

[1] An explanatory note is provided for any significant exceptions when additional information has been used as per PIRC guidelines. The full set of PIRC reporting requirements and guidelines is set out in: The Plan for FPT Reporting on 14 Indicator Areas August 1, 2002 unpublished.
[2] The Plan for FPT Reporting on 14 Indicator Areas August 1, 2002 unpublished.

and divides it by the population. Next, the number is usually multiplied by 100,000 (any factor of 10) to provide a whole number. For example, if there were 25 cases of Tuberculosis (TB) in the NWT, then the rate would be 62.5 cases of TB per 100,000 (i.e., 25 cases divided by 40,000 population, then multiplied by 100,000).

2. Age Standardization

While population-based rates ensure that differences in population size have been taken into consideration, these crude rates may still be misleading if there are substantial differences between populations being compared or if there are differences within a population at different points in time. For example, the age structure of two populations may be very different or the age structure of a single population may be different at various points in time. Since age influences the risk of most diseases and death, any differences in the crude rates between populations, or within a population over time, may be due to differences in age structure rather than differences in the risk of disease or death. For example, if the effects of age are not taken into account, observed increases in the crude death rate over time in the NWT may be due mainly to an aging population rather than changes in risk of death. To remove this effect and still provide one summary measure for the total population, it necessary to adjust for differences in age structure through a process of age standardization.

Age standardization uses the age distribution of an external reference or standard population as the basis for comparison. In this report the 1991 Canadian population was used as the reference or standard population. It is important to point out that standardized rates are not "real" rates but are fictional rates based on an arbitrarily chosen standard population. If a different standard population had been used, the magnitude of the standardized rates could be different. However, the adjusted rate can be trusted in a head to head comparison with other age-adjusted rates.

3. Statistical Measurements of Accuracy and Reliability

Measurements of data accuracy and reliability, referred to as confidence intervals and coefficient of variation (respectively), are included with some indicators. These measurements are often used with indicators that are derived from survey data. Since a survey involves making a generalization from a sample of a population to provide a picture of the whole population there is an associated risk of inaccuracy. These two statistical tools provide a way to quantify the potential levels of inaccuracy.

3.1 Confidence Intervals

Readers may be familiar with the use of confidence intervals in polls done prior to an election. A confidence interval provides the range in which a number is expected to lie (i.e., plus or minus 5%), usually 19 times out of 20. Confidence intervals also allow for comparisons between different values. For example, if the confidence intervals overlap there is not considered to be a statistically significant difference. (for example see figure 4.1) However, where the confidence intervals do not overlap, there is a statistically significant difference (for example see Figure 9.8). A complete set of confidence intervals for all indicator statistics is provided in Appendix B.

3.2 Coefficient of Variation

Another consideration when comparing survey data is the coefficient of variation (CV). The CV measures the degree to which the number provided can be considered to be reliable. The larger the sample, the lower the CV, as well as the more narrow the confidence interval. Data tables in Appendix B have CVs where survey data is used. When the CV is 16.6% to 33.3% then the data should be used with caution, and when the CV is 33.4% or higher the data should not be published, and is therefore suppressed.

3.3 Chi-Square Test

Where survey data is not used (Indicators 2, 3.5a, 6a, 6b, 7a, 7b, 12d and 13a to 13d), a chi-square test is used to determine statistically significant differences between the NWT and Canadian rates for the most recent time period compared.

Finally, the reader should be aware that any future reports on these indicators may require revisions of the data presented in this 2002 report. The main reason for changes to data is the periodic revision of population estimates by Statistics Canada. These revisions are used by the NWT Bureau of Statistics to develop more detailed estimates for the NWT. Any NWT population based rate or percentage is subject to minor revisions when Statistics Canada replaces the current estimate. Also there is the potential for database revisions when data is used from the NWT Department of Health and Social Services as these databases are updated on a constant basis, usually changing the most recent data.

Health Status

Indicators in this category are intended to reflect population health status. Four sets of broad indicators have been chosen to summarize health status: life expectancy, infant mortality, low birth weight, and self-reported health status.

1 Life expectancy

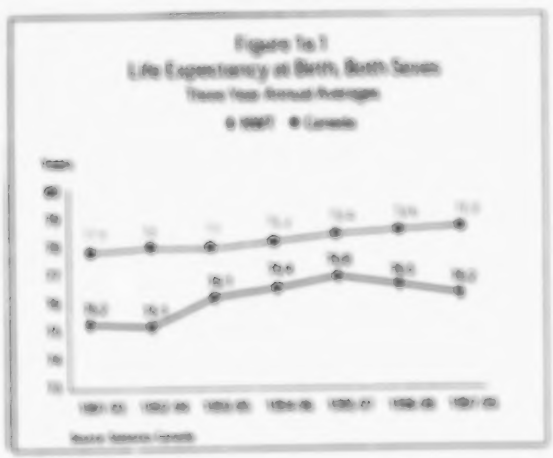
1a. Life expectancy

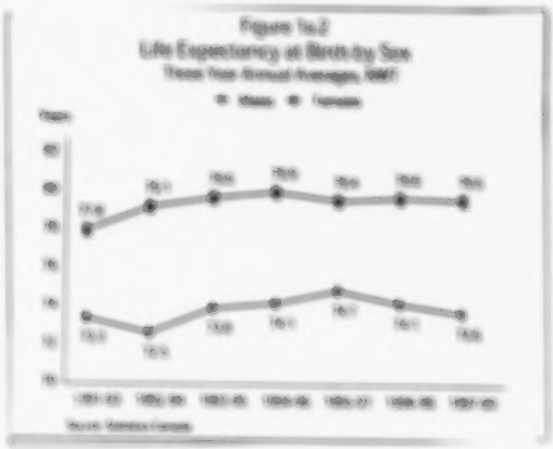
Life expectancy is a widely used indicator of the overall health of a population. In developed countries, life expectancy is higher for women than for men, and is related to socio-economic factors such as poverty and education levels. The highest life expectancies in the world in 1999 were in Japan at 84.1 years for women, and 77.3 years for men.[1]

Life expectancy at birth is a statistical artifact, calculated from the average age at which people die, and intended to facilitate comparisons among populations. How many years a newborn can actually expect to live is a function of many factors including, for example, genetics, personal health practices and lifestyle, and advancements in medicine.

As can be seen in Figure 1a.1, between 1991-93 life expectancy at birth in the NWT averaged 75.2 years and between 1997-99 average life expectancy at birth was 76.2 years. For comparison, average life expectancy at birth in Canada between 1991-93 was 77.9 years, and between 1997-99 life expectancy at birth in Canada averaged 78.8 years.

Figure 1a.2 presents life expectancy at birth in the NWT separately for women and for men. For the period 1997-99, average life expectancy at birth for women was 79.5 years, compared to 73.6 years for men.





[1] United Nations, Human Development Report 2001 as cited in The Plan for HIV Reporting on HIV Indicators, Anne Augustin, (2002 unpublished)

Life expectancy at age 65 provides an estimate of the number of years the average person can expect to live. As can be seen in Figure 1a.3, life expectancy at age 65 in the NWT averaged 16.5 years between 1991-93, and 17.1 years between 1997-99. For Canada, life expectancy at age 65 averaged 18.1 years between 1991-93, and 18.3 years between 1997-99.

Figure 1a.4 provides life expectancy at age 65 for men and women separately. Between 1991-93 and 1997-99, life expectancy at age 65 for men increased from 15.2 years to 15.9 years, and for women from 18.3 years to 18.8 years.

Figure 1a.3
Life Expectancy at Age 65, Both Sexes
Three Year Annual Averages

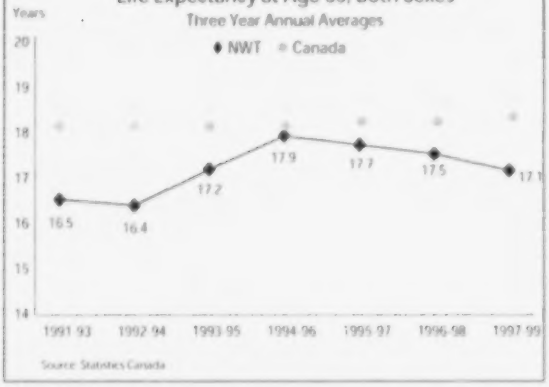
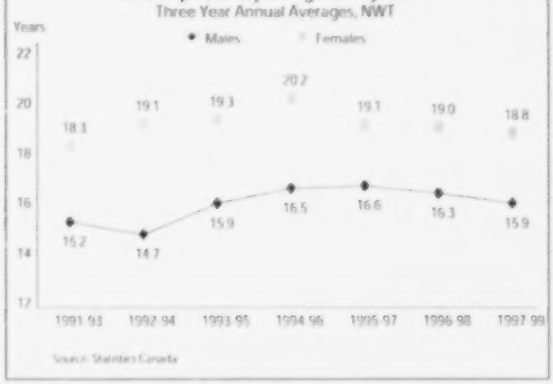


Figure 1a.4
Life Expectancy at Age 65 by Sex
Three Year Annual Averages, NWT



1b. Disability-free life expectancy

Disability-free life expectancy (DFLE) at birth or at age 65 is the number of years an average individual is expected to live free of moderate or severe disability. DFLE complements conventional life expectancy measures by providing a measure of quality of life.

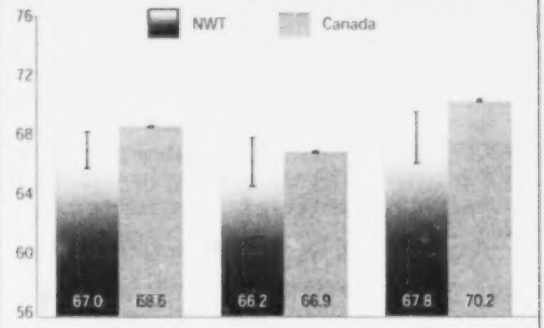
In the NWT, in 1996, the average number of disability-free years of life a person could expect to live at birth was 67 years. Women can expect a longer DFLE on average than men can. As seen in Figure 1b.1, NWT women at birth on average are expected to have 67.8 disability free years of life, compared to 66.2 for men. The comparable Canadian figures were 70.2 years for women and 66.9 years for men.

For DFLE at birth, there is a statistically significant difference between the NWT and Canada, for both sexes, and females separately, but not for males.

As seen in Figure 1b.2, DFLE at age 65 for the NWT in 1996 was 10.4 years. The average number of years of disability-free life expectancy for women was 10.3 years, compared to 10.6 for men. The comparable Canadian figures were 12.4 years for women and 10.9 years for men.

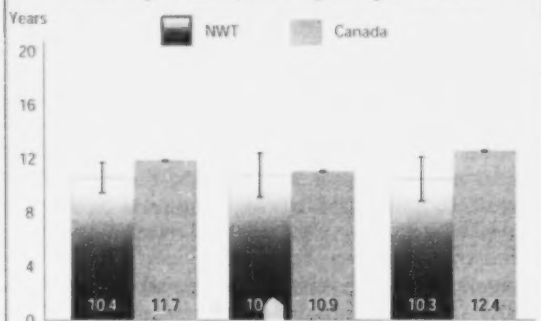
For DFLE at age 65, there is a statistically significant difference between the NWT and Canada, for both sexes, and females separately, but not for males.

Figure 1b.1
Disability-Free Expectancy at Birth, 199€



Source: Statistics Canada

Figure 1b.2
Disability-Free Expectancy at Age 65, 1996



Source: Statistics Canada

Health Status

2 Infant mortality

The infant mortality rate is a long-established measure of child health and the overall well being of a society. It reflects not only the level of mortality, but also the health status and health care of a population, the effectiveness of preventive care, and the attention paid to maternal and child health. It also reflects broader social factors, such as maternal education, smoking and relative deprivation. Generally, low birth weight is the principle risk factor associated with infant mortality in Canada.

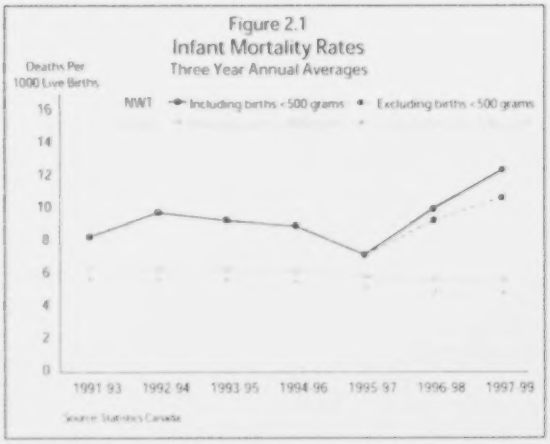
Infant mortality rates, including rates for births under 500 grams, have increased over the last decade, from 8.1 per 1,000 live births in 1991-93 to 12.2 per 1,000 in 1997-99. Excluding births under 500 grams, the increase has been less (from 8.1 to 10.5), over the same time period (See Figure 2.1).

The apparent increase in infant mortality between 1995-97 and 1997-99 was not statistically significant.

As can be seen in Figure 2.1, between 1997-99 infant mortality in Canada averaged 5.4 per 1,000 births, or 4.6 per 1,000 births when births under 500 grams were excluded.

The differences between the NWT and Canada, for both measures of infant mortality, are statistically significant for 1997-99.

Figure 2.1
Infant Mortality Rates
Three Year Annual Averages



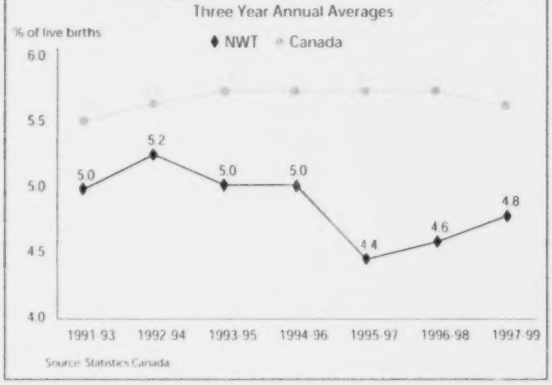
Source: Statistics Canada

3 Low birth weight

Low birth weight (births between 500 and 2499 grams) provides a general indication of the health of newborns, and is an important determinant of infant survival, health and development. Low birth weight infants are at a greater risk of dying during the first year of life, and if they survive, will have a greater risk of disability and diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems. Low birth weight is associated with multiple births (twins, triplets, etc.), pre-term births, poor maternal health, lifestyle, economic circumstances, and assisted conception. Appropriate medical care and a healthy lifestyle for the mother can improve the chances that the baby will have a healthy birth weight.

The percentage of low birth weight babies in the NWT averaged 5.0% between 1991-93, and 4.8% between 1997-99. In Canada the percentage averaged 5.5% between 1991-93, and 5.6% between 1997-99. The difference between the NWT and Canada, for low birth weight, is not statistically significant for 1997-99.

Figure 3.1
Percentage of Live Births with Low Birthweight
Three Year Annual Averages



Source: Statistics Canada

4 Self-reported health

Self-reported health is a general indicator of the overall health of individuals. It captures some of what other measures may miss such as: the early states of disease, disease severity, positive health status, as well as social and mental functioning.

Self-reported health data are collected using a five-point reporting scale, ranging from excellent to poor. Studies indicate that when individuals rate their health in response to this question, they tap into information that has important predictive power relating to chronic disease incidence, functional decline and ultimately survival. Numerous longitudinal studies have found that self-reported health is predictive of mortality even when more objective measures such as clinical evaluations are taken into account.

Between 1994 and 2001, there have been four national surveys[4] which have asked a sample of residents from the NWT about their health, lifestyle and other social and economic characteristics. Self-reported health status for the NWT is presented in Figures 4.1 and 4.2.[5]

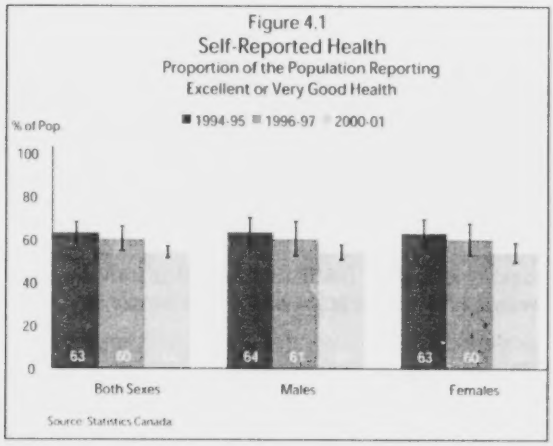
As seen in Figure 4.1, the percentage of the population reporting excellent or very good health was 63% in 1994-95, 60% in 1996-97 and 54% in 2000-01. There is no statistically significant difference between the values for 1994-95 and 1996-97, and no statistically significant difference between the values for 1996-97 and 2000-01. However, there is a statistically significant decline between 1994-95 and 2000-01 in the proportion of the population reporting excellent or very good health.

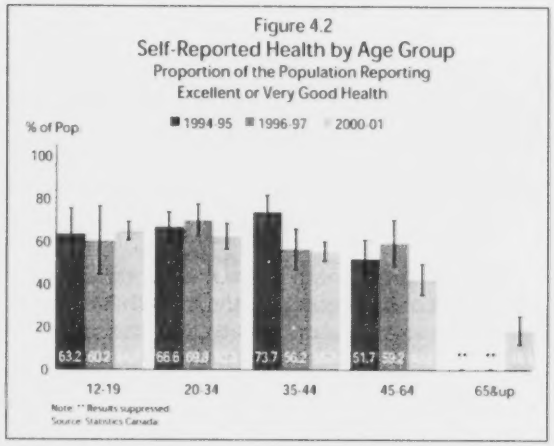
[4] Statistics Canada, 1994/95, 1996/97 and 1998/99 National Population Health Surveys. Statistics Canada, 2000-01 Canadian Community Health Survey
[5] NWT data from the 1998-99 National Population Health Survey were not used in this report due to the small size of the sample from the NWT

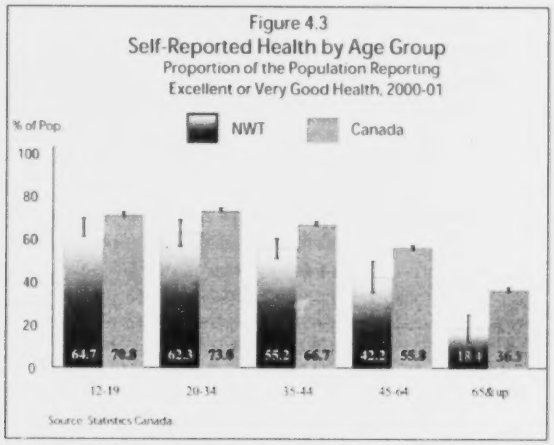
There was no significant difference between males and females in any of the three survey years, nor were the declines over time statistically significant.

Figure 4.2 provides the proportion of NWT residents reporting excellent or very good health by age group. There is only one statistically significant change in self-reported health for the 35 to 44 year olds. In 1994-95, 73.7% of the population surveyed in this age group reported excellent or very good health. In 2000-01, however, the proportion dropped to 55.2%. The changes seen within all the other age groups are not statistically significant. [6]

Figure 4.3 provides a 2000-01 comparison of NWT and Canada residents by age reporting their health to be excellent or very good. Statistically significant differences, between the NWT and Canada, occur for all age groups.







[6] 1994-95 and 1996-97 survey results for NWT residents age 65 and up had to be suppressed due to small sample sizes. The 2000-01 results for seniors, age 65 and up, should be treated with caution due to the CV being 18.2.

Health Outcomes

Indicators in this area are intended to reflect the impact of health system programs and services on health status. The extent to which particular health outcomes are attributable to health programs and services is difficult to assess based on indicator data alone. Where possible, indicators have been selected where the link between particular interventions and impact on health outcomes has been well established through research. Although some health system interventions save lives, most interventions are designed to improve health-related quality of life. This is the intended outcome of joint-replacement surgery, and research evidence supports the effectiveness of this surgery in improving health-related quality of life. [7]

5 Change in life expectancy.

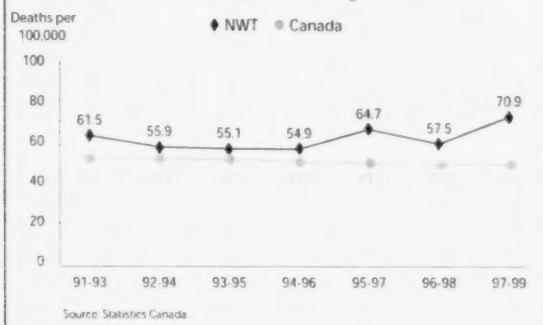
5a. Mortality rates for lung, prostate, breast and colorectal cancer, acute myocardial infarction and stroke.

Age-standardized[8] death rate trends for cancer, acute myocardial infarction (AMI)[9] or stroke may indicate long-term success in reducing deaths from these diseases. Lower death rates indicate success in cancer or cardio-vascular disease prevention, detection, and treatment.

Figure 5a.1 shows the age-standardized rate for lung cancer. Between 1991-93 in the NWT, the average was 61.5 deaths per 100,000, rising to 70.9 deaths per 100,000 by 1997-99. By comparison, lung cancer mortality in Canada averaged 50.7 deaths per 100,000 population between 1991-93, and 49.3 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to lung cancer, is statistically significant for 1997-99.

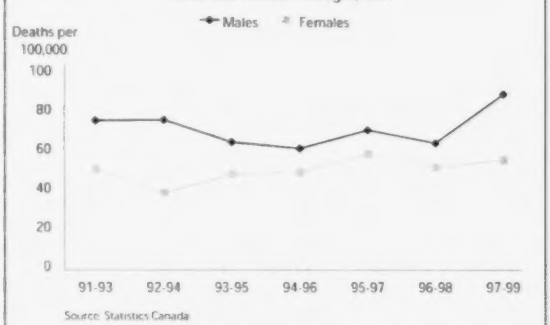
Figure 5a.2 shows the rate of deaths due to lung cancer by sex in the NWT. For males, the rate of lung cancer deaths has increased from 73.4 per 100,000 in 1991-93 to 86.9 per 100,000 in 1997-99. For females the increase has been relatively lower over the same period of time, rising from 48.7 to 53.4 deaths.

Figure 5a.1
Lung Cancer Mortality - Age Standardized Rate
Three Year Annual Averages



Source: Statistics Canada

Figure 5a.2
Lung Cancer Mortality - Age Standardized Rate
Three Year Annual Averages, NWT

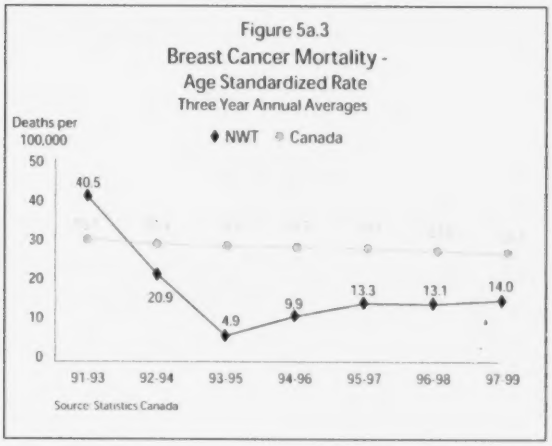


Source: Statistics Canada

[7] Hip and knee replacement survey rates are surrogate indicators of improved quality of life until more comparable and specific measures of patient function and pain, associated with various health conditions, are in place across the country.
[8] All age standardized rates are standardized to the 1991 Canadian standard population.
[9] AMI is the death of the muscular tissue of the heart, as a result of an interruption of the blood supply to the heart area, commonly referred to as a heart attack.

Figure 5a.3 shows the breast cancer death rate. In the NWT the age-standardized rate averaged 40.5 deaths per 100,000 population between 1991-93, and 14.0 deaths per 100,000 between 1997-99. In Canada the breast cancer death rate averaged 30.0 deaths per 100,000 between 1991-93, and 26.3 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to breast cancer, is not statistically significant for 1997-99.

Figure 5a.4 shows the prostate cancer death rate. In the NWT the age-standardized death rate averaged 20.9 deaths per 100,000 population between 1991-93, and 21.3 deaths per 100,000 between 1997-99. In Canada the prostate cancer death rate averaged 31.1 deaths per 100,000 between 1991-93, and 27.7 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to prostate cancer, is not statistically significant for 1997-99.



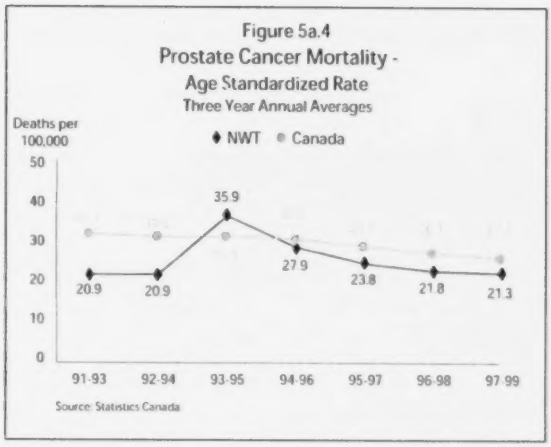
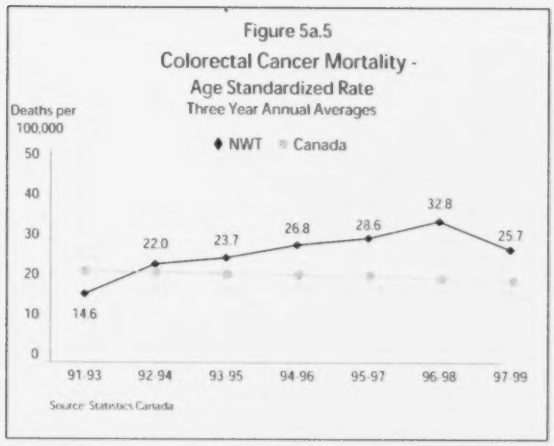


Figure 5a.5 shows the age-standardized rate for death due to colorectal cancer. The death rate due to colorectal cancer in the NWT has increased from 14.6 to 25.7 per 100,000 between 1991-93 and 1997-99. By comparison, colorectal cancer mortality in Canada averaged 20.3 deaths per 100,000 between 1991-93, and 19.0 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to colorectal cancer, is not statistically significant for 1997-99.

Figure 5a.6 provides the death rate due to colorectal cancer by sex in the NWT. For males, the rate has increased from 11.1 to 26.7 per 100,000 between 1991-93 and 1997-99. For females, the rate has increased from 21.0 to 25.2 per 100,000.



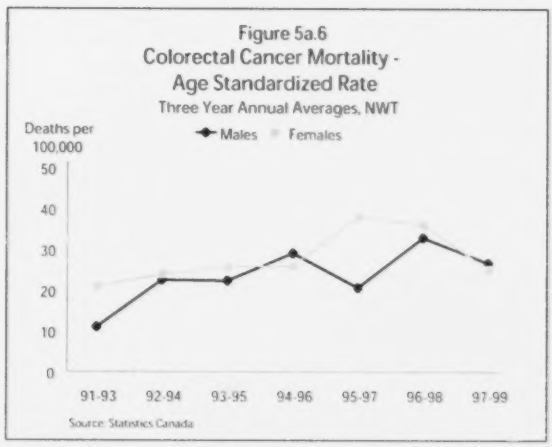
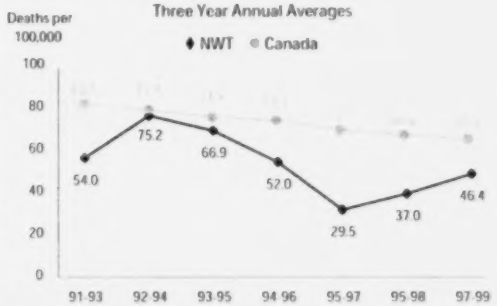


Figure 5a.7 shows the age-standardized rate for death due to acute myocardial infarction (AMI). The death rate for AMI has decreased from 54.0 per 100,000 in 1991-93 to 46.4 in 1997-99. Even with using three-year averages to express the rates, there have been wide swings in the AMI death rate. For example, the rate was 75.2 per 100,000 in 1992-94 and in 1995-97 it was 29.5 per 100,000. In Canada the AMI death rate averaged 80.8 deaths per 100,000 between 1991-93, and 63.5 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to AMI, is not statistically significant for 1997-99.

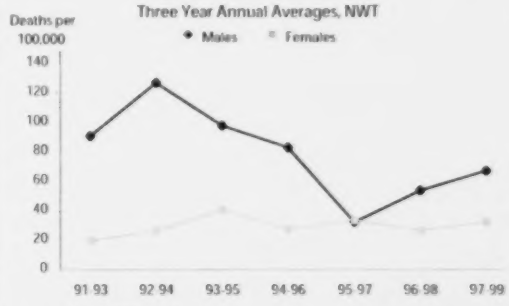
Figure 5a.8 provides the AMI death rate by sex in the NWT, with male deaths decreasing from 87.5 per 100,000 in 1991-93 to 63.7 per 100,000 in 1997-99, and female deaths increasing from 16.6 to 29.2, over the same time period.

Figure 5a.7
Acute Myocardialinfarction (AMI) Mortality - Age Standardized Rate
Three Year Annual Averages



Source: Statistics Canada

Figure 5a.8
Acute Myocardialinfarction (AMI) Mortality - Age Standardized Rate
Three Year Annual Averages, NWT

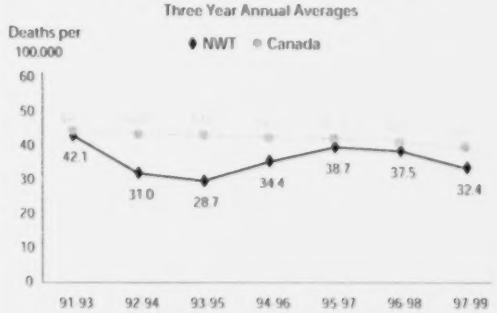


Source: Statistics Canada

Figure 5a.9 shows the age-standardized rate of death due to stroke. In 1991-93, the average death rate for stroke was 42.1 versus 32.4 per 100,000 in 1997-99. In Canada the death rate due to stroke averaged 44.1 deaths per 100,000 between 1991-93, and 39.1 deaths per 100,000 between 1997-99. The difference between the NWT and Canada, for mortality due to stroke, is not statistically significant for 1997-99.

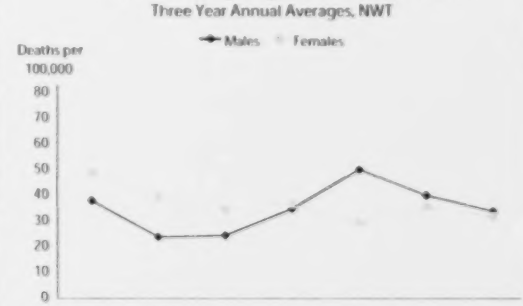
Figure 5a.10 provides the stroke death rate by sex in the NWT. For males the rate decreased from 36.5 per 100,000 in 1991-93 to 32.4 per 100,000 in 1997-99, and for females, it decreased from 47.7 to 30.5 per 100,000.

Figure 5a.9
Stroke Mortality - Age Standardized Rate
Three Year Annual Averages



Source: Statistics Canada

Figure 5a.10
Stroke Mortality - Age Standardized Rate
Three Year Annual Averages, NWT



Source: Statistics Canada

5b. Five-year relative survival rates for lung, prostate, breast and colorectal cancer

Given the NWT's small population, the rate for this indicator is too small to report in a reliable manner.

5c. 30-day acute myocardial infarction mortality rate

Given the NWT's small population, the rate for this indicator is too small to report in a reliable manner.

5d. 30-day stroke mortality rate

Given the NWT's small population, the rate for this indicator is too small to report in a reliable manner.

5e. 365-day survival rate for acute myocardial infarction

Given the NWT's small population, the rate for this indicator is too small to report in a reliable manner.

5f. 180-day survival rate for stroke

Given the NWT's small population, the rate for this indicator is too small to report in a reliable manner.

6 Improved quality of life

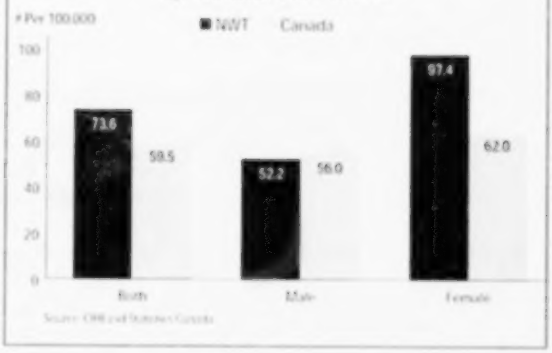
6a. Total hip replacement rate

The intended outcome of most elective surgery is improved health-related quality of life. Hip replacement improves functionality and reduces the pain that had previously burdened the patient.

As seen in Figure 6a.1, the age standardized hip replacement rate for the NWT was 73.6 per 100,000 in 1999-00.[10] For males the rate was 52.2 hip replacements per 100,000 and for females the rate was 97.4 per 100,000. Comparable Canadian figures were 59.5 hip replacements per 100,000 overall, with the male rate at 56.0 replacements and the female rate at 62.0 replacements per 100,000 population.

The differences between the NWT and Canada, for both sexes, and for males, are not statistically significant. However, the NWT hip replacement rate for females is significantly higher than the corresponding national rate.

Figure 6a.1
Total Hip Replacement
Age Standardized Rate, 1999/00



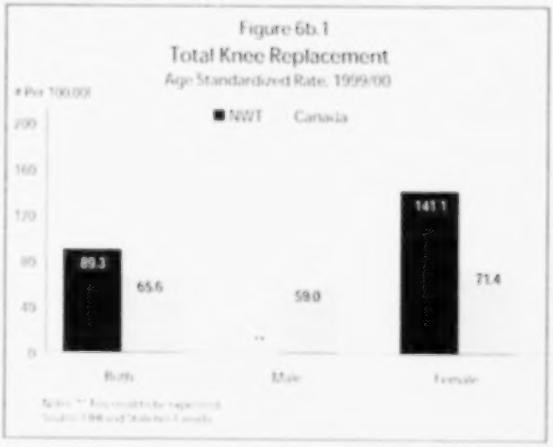
6b. Total knee replacement rate

Similar to hip replacements, knee replacements generally improve the patient's ability to function and reduce the pain previously associated with the original knee.

As seen in Figure 6b.1, the age standardized knee replacement rate for the NWT was 89.3 per 100,000 in 1999-00. The number of knee replacements for male residents of the NWT was too small to express as a rate. However, the knee replacement rate for females was 141.1 per 100,000 for 1999-00. Comparable Canadian figures were 65.6 knee replacements per 100,000 population overall, with the female rate at 71.4 replacements per 100,000.

The difference between the NWT and Canada, for both sexes is not statistically significant. However, the NWT knee replacement rate for females is significant higher than the corresponding national rate.

Figure 6b.1
Total Knee Replacement
Age Standardized Rate, 1999/00



[10] There is only one year of data (1999-00) available for the NWT for hip and knee replacements. Previous years of data had combined Nunavut with the NWT. The data for this indicator came from the Canadian Institute for Health Information (CIHI) and Statistics Canada.

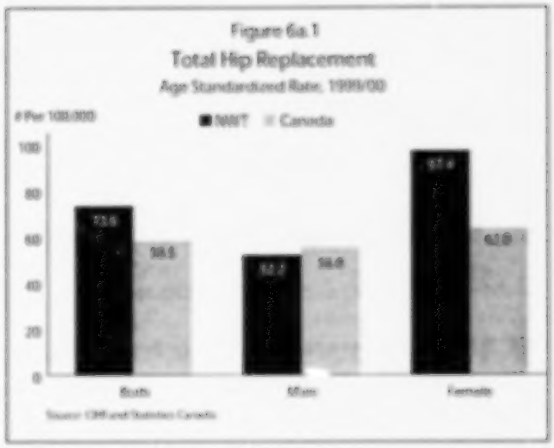
6 Improved quality of life

6a. Total hip replacement rate

The intended outcome of most elective surgery is improved health-related quality of life. Hip replacement improves functionality and reduces the pain that had previously burdened the patient.

As seen in Figure 6a.1, the age standardized hip replacement rate for the NWT was 73.6 per 100,000 in 1999-00.[16] For males the rate was 52.2 hip replacements per 100,000 and for females the rate was 97.4 per 100,000. Comparable Canadian figures were 59.5 hip replacements per 100,000 overall, with the male rate at 56.0 replacements and the female rate at 62.0 replacements per 100,000 population.

The differences between the NWT and Canada, for both sexes, and for males, are not statistically significant. However, the NWT hip replacement rate for females is significantly higher than the corresponding national rate.

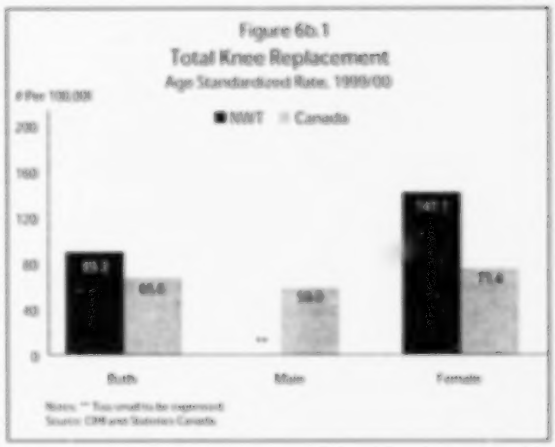


6b. Total knee replacement rate

Similar to hip replacements, knee replacements generally improve the patient's ability to function and reduce the pain previously associated with the original knee.

As seen in Figure 6b.1, the age standardized knee replacement rate for the NWT was 89.3 per 100,000 in 1999-00. The number of knee replacements for male residents of the NWT was too small to express as a rate. However, the knee replacement rate for females was 141.1 per 100,000 for 1999-00. Comparable Canadian figures were 65.6 knee replacements per 100,000 population overall, with the female rate at 71.4 replacements per 100,000.

The difference between the NWT and Canada, for both sexes is not statistically significant. However, the NWT knee replacement rate for females is significant higher than the corresponding national rate.



[16] There is only one year of data (1999-00) available for the NWT for hip and knee replacements. Previous years of data had combined Nunavut with the NWT. The data for this indicator came from the Canadian Institute for Health Information (CIHI) and Statistics Canada.

7 Reduced burden of disease, illness and injury

7a. Incidence rates for lung, prostate, breast, and colorectal cancer

Age-standardized incidence rates measure the appearance of new cancers. This incidence rate is influenced by two main factors:

(1) the underlying rate of cancer incidence, which in turn reflects, in part, the prevalence of risk factors such as smoking, and hence the success of primary prevention efforts; and
(2) the rate of detection and diagnosis of cancers, which in turn can be influenced by the intensity and effectiveness of cancer screening programs.

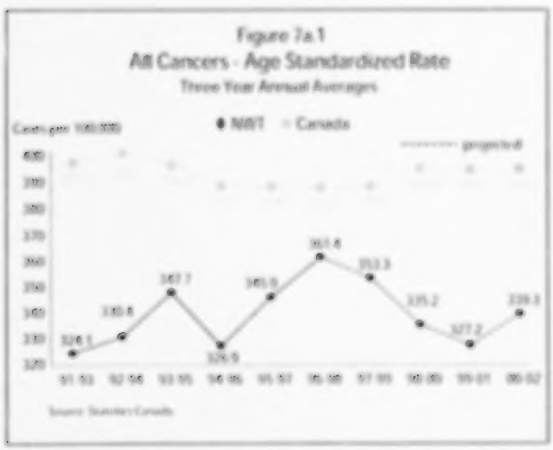
These two factors can work in opposite directions. For example, an increase in measured cancer incidence could reflect either an absolute increase in cancers or an improvement in screening. However, the impact of improved screening is unlikely to carry on for a long period of time. Given this, a declining incidence of cancer suggests a positive change in population health.

In total, the number of NWT cancer cases between 1992 and 2000 was 676 - approximately 75 cases a year. Given the small number of cases, the rates are subject to a great deal of fluctuation from year to year - especially when focusing on any one type of cancer. As with other indicators, three-year averages have been used for the purposes of smoothing out these fluctuations.

The reader should be aware that even by using three-year averages, NWT cancer trends are highly influenced by a change of one or two cases each year. Another note of caution is that the data for the years 1998 to 2002 are forecasted (denoted by dotted lines), based on information from the prior years, and are therefore subject to future revisions. Finally, combined cancer rates for both sexes for 1998 to 2002 are estimated by adding the male and female rate together, then dividing by two.

Figure 7a.1 shows the age-standardized rate for all cancers**. Between 1991-93, the average NWT rate was 324.1 per 100,000, increasing slightly to a forecasted 339.3 per 100,000 by 2000-02. For Canada, there was an annual average of 397.2 cases of cancer per 100,000 population between 1991-93, with a projected annual average of 394.6 cases per 100,000 in 2000-02. The difference between the NWT and Canada, for all cancers, is not statistically significant for 2000-02.

Figure 7a.2 provides the trend for males and females in the NWT. The rate for males has increased from 312.6 cases per 100,000 in 1991-93 to a forecasted rate of 355.4 per 100,000. The rate for females has decreased from 340.9 to 323.2 per 100,000 over the same time period.



** The focus of this indicator is on specific cancers. However, given the small numbers of cancer cases in the NWT, it is useful to show the rate for all cancers.

Figure 7a.3 shows the age-standardized rate for lung cancer. In 1991-93 the average NWT rate was 64.9 cases per 100,000. By 2000-02, the forecasted NWT rate had decreased slightly to 59.2 cases per 100,000, below the twelve-year average of 62.1 cases per 100,000. The Canadian lung cancer rates ranged from an average 61.6 cases per 100,000 between 1991-93 to a projected 60.9 cases per 100,000 between 2000-02. The difference between the NWT and Canada for lung cancer is not statistically significant for 2000-02.

Figure 7a.4 presents the age-standardized lung cancer rates by sex in the NWT. The age-standardized lung cancer rate for males has decreased from 84.9 cases per 100,000 in 1991-93 to 71.9 projected cases per 100,000 in 2000-02. The average for the entire twelve-year period was 76.2 cases per 100,000. On the other hand, the lung cancer rate for females has increased slightly over the same time period, from 40.6 to 46.5 cases per 100,000.

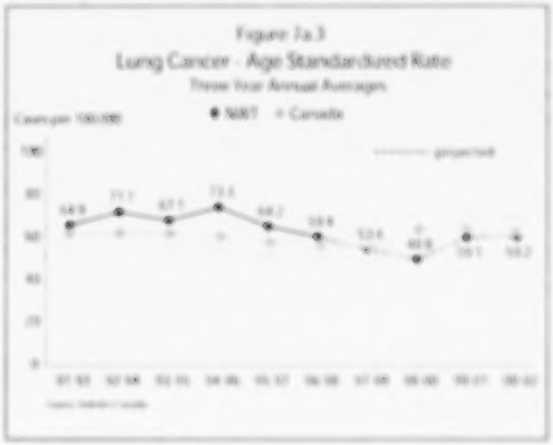


Figure 7a.5 shows the age-standardized rates for breast cancer. In the NWT the annual average was 63.7 cases per 100,000 population between 1991-93, and is projected to be 87.0 cases per 100,000 annually between 2000-02. The Canadian rate averaged 100.4 cases per 100,000 between 1991-93, and is projected to be 105.3 cases annually per 100,000 by 2000-02. The difference between the NWT and Canada, for breast cancer, is not statistically significant for 2000-02.

Figure 7a.6 shows the age-standardized rates for prostate cancer. In the NWT the annual average was 52.2 cases per 100,000 population between 1991-93, and is projected to be 53.6 cases per 100,000 annually between 2000-02. The Canadian rate averaged 126.0 cases per 100,000 between 1991-93, and is projected to be 118.2 cases annually per 100,000 by 2000-02. The difference between the NWT and Canada, for prostate cancer, is statistically significant for 2000-02.

Figure 7a.7 shows the age-standardized rate for colorectal cancer. Between 1991-93 and 2000-02, the rate of colorectal cancer has steadily increased from 54.2 to 81.1 projected cases per 100,000. By comparison, the Canadian rates were 51.7 cases per 100,000 on average between 1991-93, and projected to be 49.5 cases per 100,000 on average between 2000-02. The difference between the NWT and Canada for colorectal cancer is statistically significant for 2000-02.

Figure 7a.8 provides the age-standardized rate of colorectal cancer for males and females in the NWT. For males, the rate of colorectal cancer has more than doubled between 1991-93 and 2000-02, from 37.4 to 90.3 projected cases per 100,000. In sharp contrast, the rate of colorectal cancer in females has remained relatively the same, despite relatively large fluctuations in the 1990s. In 1991-93 there were 75.3 cases per 100,000 of colorectal cancer in women compared to a projected 71.8 per 100,000 by 2000-02.

Figure 7a.7

Colorectal Cancer - Age Standardized Rate

Three-Year Annual Averages

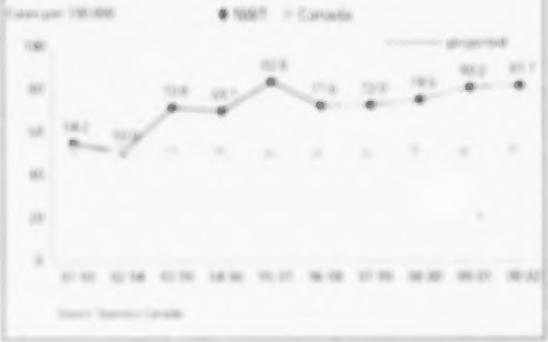
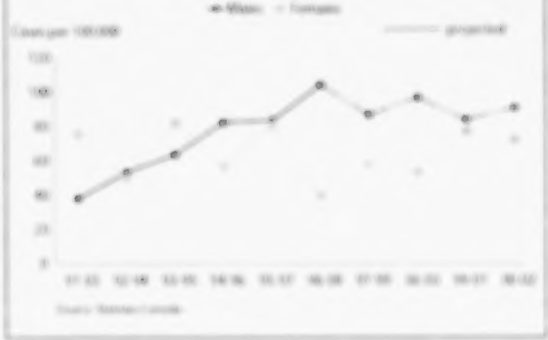


Figure 7a.8

Colorectal Cancer - Age Standardized Rate

Three-Year Annual Averages, NWT



7b. Potential years of life lost due to lung, prostate, breast and colorectal cancer, acute myocardial infarction, stroke, suicide, and unintentional injury

The most widely used mortality-based indicator of population health is life expectancy. It measures the average expectation of life, and therefore reflects both changing lengths of life for seniors, and changes in mortality rates for the non-elderly. Potential years of life lost (PYLL) is a complementary indicator focusing on mortality amongst the non-elderly (under age 75). It reflects the level of success in preventing premature loss of life, with its consequent loss of social and economic productivity. It is an overall indicator of population health and well-being, as well as effectiveness of preventive programs.[1]

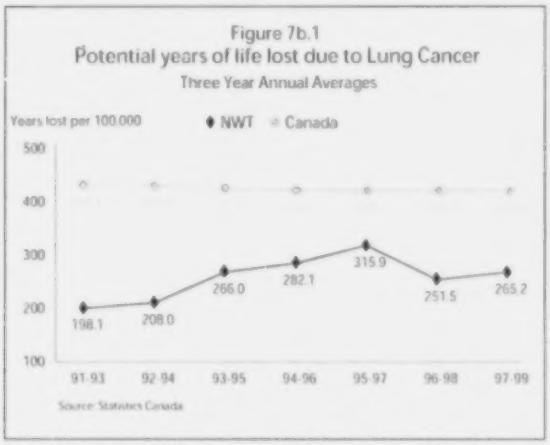
PYLL is calculated by assuming that an average productive life span is 75 years, and by subtracting the age at which a person dies from 75. For example, if a person dies at age 50, then the potential years of life lost by premature death is 25 years. The PYLL for an entire population is simply the sum of all the years of life lost by those who died prior to reaching the age of 75.

The reader should be aware that the NWT's small population causes the rate of PYLL to fluctuate over time. In some years it is possible there may not be a single death due to some diseases (i.e. prostate cancer and stroke) before the age of 75.

[1] It should be noted that, at older ages, co-morbidity becomes very frequent and death is often the result of a complex process. This can make PYLL more meaningful for diseases that can be identified as the sole cause of death and for those that kill at an early age. Unfortunately, PYLL is only based on single cause-of-death statistics.

Figure 7b.1 shows PYLL due to lung cancer. In the NWT the annual average PYLL was 198.1 years lost per 100,000 population between 1991-93, and was 265.2 years lost per 100,000 between 1997-99. For Canada, average lung cancer PYLL was 434.8 years lost per 100,000 between 1991-93, and was 410.4 years lost per 100,000 between 1997-99. The difference between the NWT and Canada, for PYLL due to lung cancer, is statistically significant for 1997-99.

Figure 7b.2 provides the rate of PYLL by sex for the NWT. For males the rate was 274.2 per 100,000 in 1991-93, decreasing marginally to 271.5 per 100,000 in 1997-99. For females the rate of PYLL increased from 113.7 to 258.6 per 100,000 in the same period.



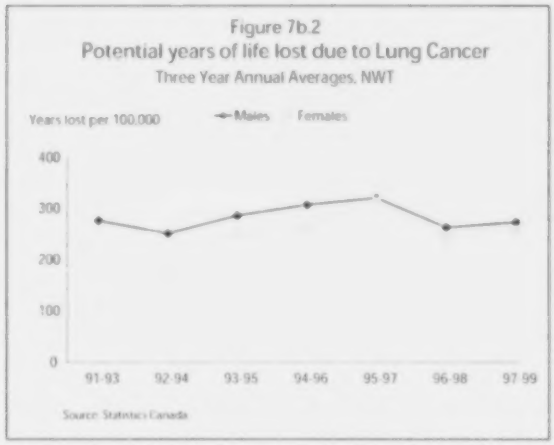
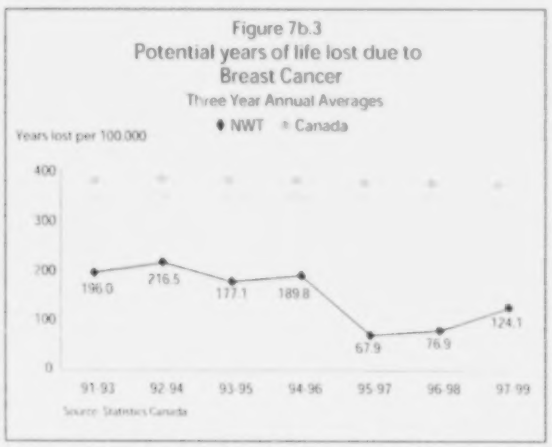


Figure 7b.3 shows PYLL due to breast cancer. Between 1991-93, the NWT rate was 196 years per 100,000. By 1997-99, the rate for breast cancer had decreased to 124.1 years per 100,000. While the rate has decreased, it has fluctuated widely in the period between the two aforementioned dates. In some years there were not any deaths before age 75 that were due to breast cancer. For Canada, average breast cancer PYLL between 1991-93 was 380.1 years per 100,000 population, and was 350.3 years per 100,000 between 1997-99. The difference between the NWT and Canada, for PYLL due to breast cancer, is statistically significant for 1997-99.

Figure 7b.4 shows PYLL for prostate cancer. In the NWT average prostate cancer PYLL was 109.5 years per 100,000 between 1991-93, and was 47.0 years per 100,000 between 1997-99. By comparison, the Canadian averages were 68.4 years per 100,000 between 1991-93 and 58.4 years per 100,000 between 1997-9. The difference between the NWT and Canada, for PYLL due to prostate cancer, is not statistically significant for 1997-99.



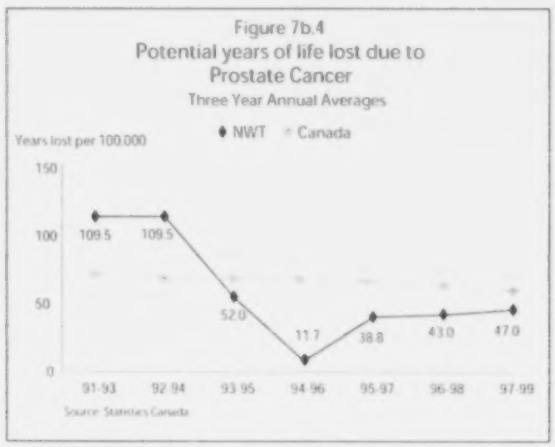
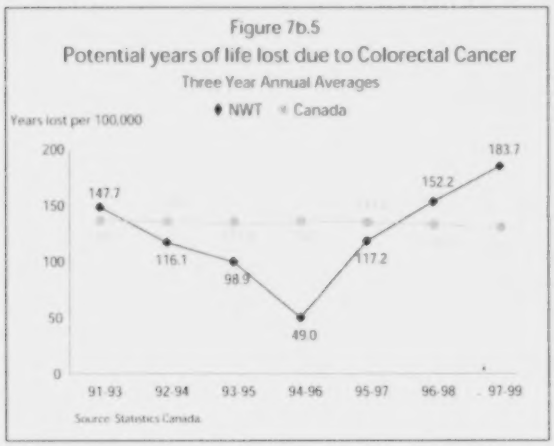


Figure 7b.5 shows PYLL due to colorectal cancer. Between 1991-93 and 1997-99, the rate NWT of PYLL due to colorectal cancer increased from 147.7 to 183.7 years per 100,000. Once again, there was a great deal of variation in the rate of PYLL in the period in between these two dates. The Canadian rate of PYLLdue to colorectal cancer was 138.9 between 1991-93 and 135 between 1997-99. The difference between the NWT and Canada, for PYLL due to colorectal cancer, is statistically significant for 1997-99.

Figure 7b.6 shows PYLL per 100,000 by sex in the NWT. For men, the rate increased from 143.0 to 220.7 per 100,000 between 1991-93 and 1997-99. For women, the rate decreased slightly from 152.8 to 144.1 years over the same time period.



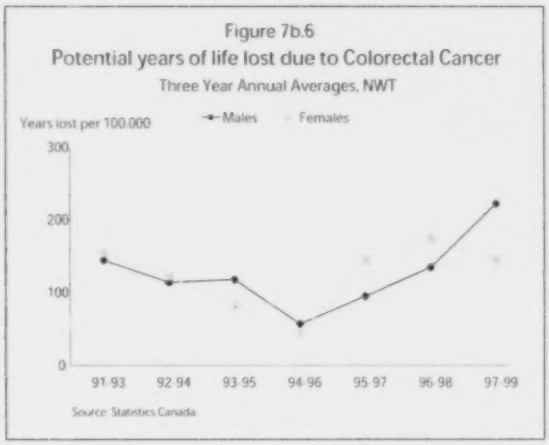
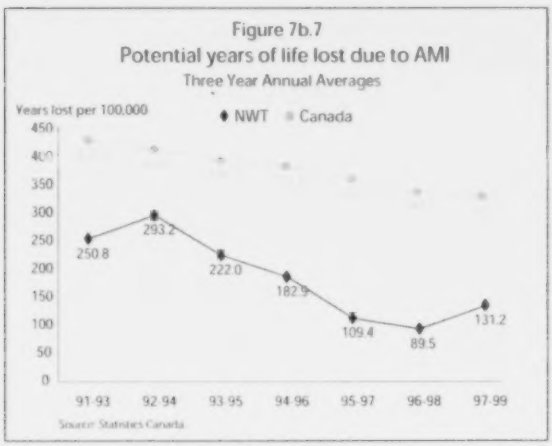


Figure 7b.7 shows PYLL per 100,000 for deaths due to AMI. Between 1991-93 and 1997-99, the NWT rate of PYLL due to AMI decreased from 250.8 to 131.2 years per 100,000. Over the same time period the Canadian rate moved from 428.0 to 325.7 years per 100,000 population. The difference between the NWT and Canada, for PYLL due to AMI, is statistically significant for 1997-99.

As seen in Figure 7b.8, the NWT rate of PYLL due to AMI for men dropped from 353.8 to 177.8 years per 100,000, and the rate for women dropped from 137.1 to 80.9 years per 100,000. Once again there was a fair degree of variability in the rate of PYLL from one year to the next.



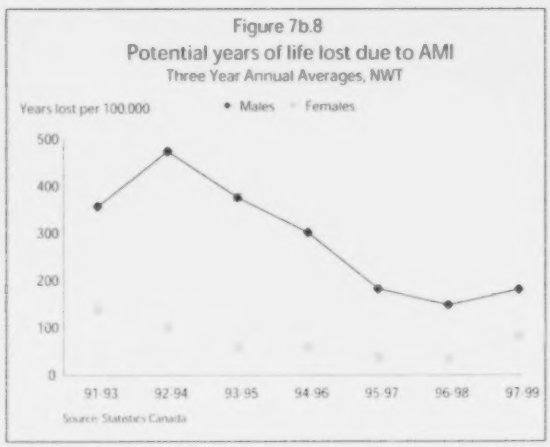


Figure 7b.9 shows PYLL per 100,000 for deaths due to stroke. Between 1991-93 and 1997-99, the average rate of PYLL in the NWT decreased from 115.1 to 67.4 years per 100,000. Over the same time period the Canadian rate went from 155.2 to 132.8 years per 100,000 population. The difference between the NWT and Canada, for PYLL due to stroke, is statistically significant for 1997-99.

For males in the NWT, as seen in Figure 7b.9, the rate of PYLL per 100,000 for deaths due to stroke increased from 82.3 to 105.8 years per 100,000 between 1991-93 and 1997-99. For females, the rate decreased from 151.5 to 25.7 years per 100,000.

Figure 7b.9
Potential years of life lost due to Stroke
Three Year Annual Averages

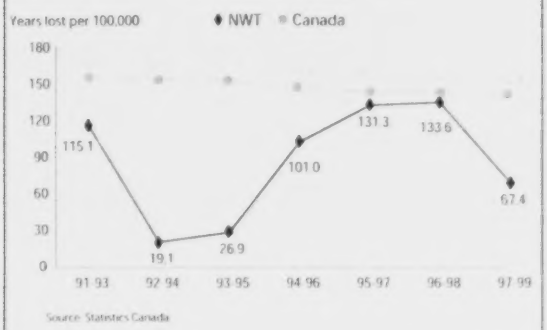


Figure 7b.10
Potential years of life lost due to Stroke
Three Year Annual Averages, NWT

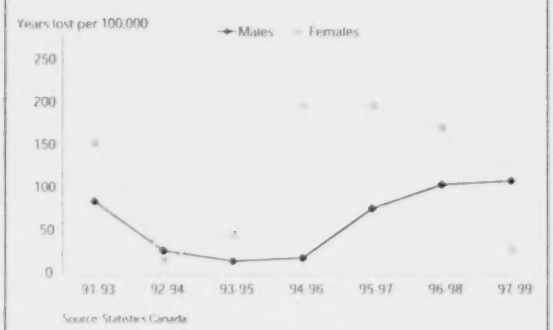


Figure 7b.11 shows PYLL per 100,000 for deaths from suicide. Between 1991-93 in the NWT, the rate of PYLL due to suicide was 734.0 years per 100,000. After dropping between 1992-94 and 1996-98, the rate had increased to 960.4 years per 100,000 in 1997-99. Given that suicides often happen in the 15 to 29 year old age group, a change in one or two suicides from one year to the next can inflate or deflate this statistic by a large amount. The Canadian rates for PYLL due to suicide were 459.8 years per 100,000 population between 1991-93, and 430.8 years per 100,000 between 1997-99. The difference between the NWT and Canada, for PYLL due to suicide, is statistically significant for 1997-99.

Moreover, as seen in Figure 7b.12, the NWT rate of PYLL due to suicide by sex can change dramatically from one three-year period to the next. Males tend to commit suicide more frequently than females. The rate of PYLL due to suicide for men was 5 to 10 times higher than for women at any given point between 1991-93 and 1997-99.

Figure 7b.11
Potential years of life lost due to Suicide
Three Year Annual Averages

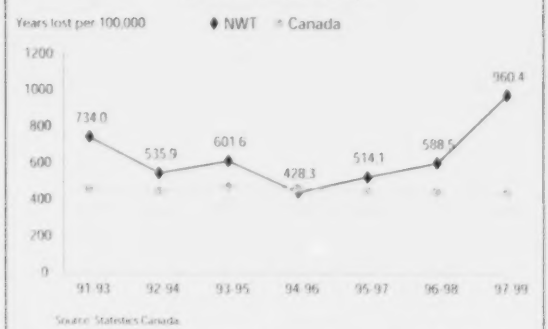


Figure 7b.12
Potential years of life lost due to Suicide
Three Year Annual Averages, NWT

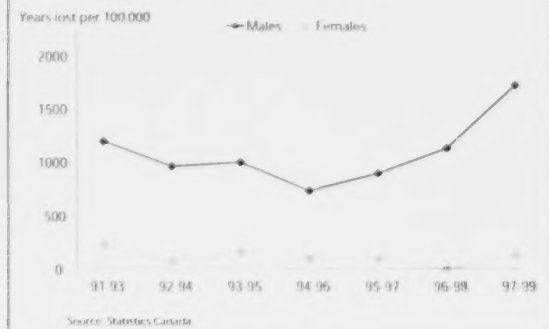


Figure 7b.13 provides PYLL for deaths due to unintentional injury. Between 1991-93 and 1997-99 in the NWT there has been a steady decrease in the rate of PYLL due to unintentional injuries, from 2,354.8 to 1,309.2 years per 100,000 population. Across the same time period, PYLL due to injuries in Canada declined slightly from 864.2 to 696.6 per 1,000,000. The difference between the NWT and Canada, for PYLL due to unintentional injury, is statistically significant for 1997-99.

As seen in Figure 7b.14, the decrease in PYLL for deaths due to an unintentional injury has occurred in both the male and female population. The rate of PYLL due to unintentional injuries has decreased from 3,169.9 to 2,050.8 years per 100,000 for men, and from 1,451.7 and 508.1 years per 100,000 for women.

Figure 7b.13
Potential years of life lost due to Unintentional Injuries
Three Year Annual Averages

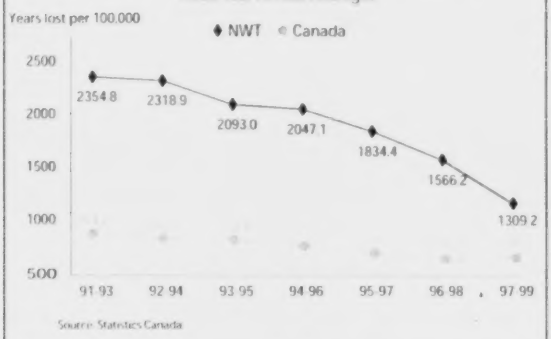
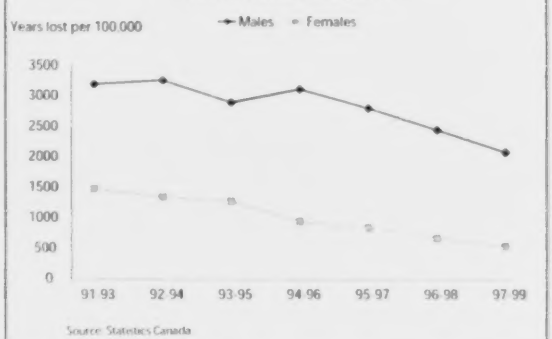


Figure 7b.14
Potential years of life lost due to Unintentional Injuries
Three Year Annual Averages, NWT



7c. Incidence rates of vaccine-preventable diseases[13]

7c (i) Invasive meningococcal disease (age under 20 Years)
Very effective vaccines are available against invasive meningococcal disease[14], and can be given to infants as young as two months old. There has not been a case of invasive meningococcal disease amongst 0 to 19 year olds in the NWT since 1997. Between 1991 and 1997, there were 4 cases of invasive meningococcal disease in the NWT population under the age of 20. One of the four cases was a serogroup C case.[15]

7c (ii) Measles
All provinces and territories have adopted a goal of eliminating measles by the year 2000. There has not been a case of measles since 1992 in the NWT. Between 1991 and 1992, there were 12 cases of measles in the NWT population.

7c (iii) Haemophilus influenzae b (invasive) (Hib) disease (age under 5 years)
Before the introduction of Hib vaccines, Hib was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children. There has not been a case in children under the age of five in the NWT since 1994. Between 1991 and 1994 there were 2 cases of Hib amongst children in the NWT.

7d. Prevalence of diabetes

Currently, comprehensive and comparable data on the prevalence of diabetes in the NWT are not available. However, the NWT is currently developing a database as part of the National Diabetes Surveillance Strategy, and diabetes data should be available for future publications of this report.

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[13] All NWT data for vaccine-preventable diseases are from the NWT Department of Health and Social Services.
[14] Invasive meningococcal disease can cause bacterial meningitis. Since the decline of Haemophilus influenzae b as a cause of bacterial meningitis, invasive meningococcal disease has become the more prominent cause of meningitis.
[15] Serogroup C refers to the particular strain of invasive meningococcal disease. Identifying the strain is important, as vaccines are strain specific.

Quality of Service

Indicators in this category reflect several aspects of health service quality (eg., appropriateness, effectiveness, accessibility). The indicators do not address all dimensions of service quality (eg., efficiency, safety) primarily due to the limitations of existing data. Data for these indicators are generally based on administrative data sources specific to each province or territory.

8 Waiting times for key diagnostic and treatment services

Currently, the NWT Department of Health and Social Services does not collect comprehensive data on waiting times.

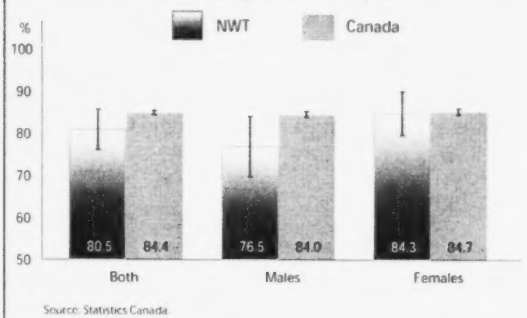
9 Patient satisfaction

Patient satisfaction with health care services is a pressing issue across Canada. In the 2000-01 Canadian Community Health Survey (CCHS), people were asked their opinion of the quality of services they received, as well as their level of satisfaction with the services for the following service areas: (a) overall health care services, (b) services received in a hospital, (c) services received from a family doctor or other physician, and (d) community-based services. Only people age 15 and over who received a service in the previous 12 months were asked to rate the services.

As seen in Figure 9.1, 80.5% of the NWT population rated the quality of overall health services to be excellent or very good, compared to 84.4% of the Canadian population. The difference between the NWT and Canada is not statistically significant.

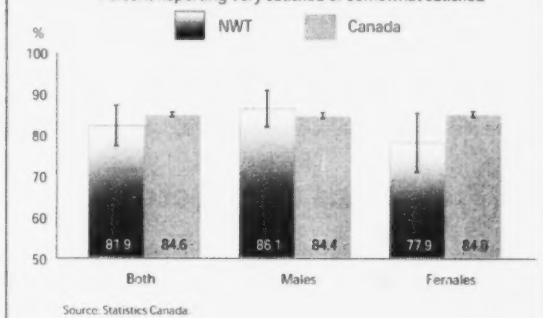
Figure 9.2 shows that when people in the NWT were asked to report their level of satisfaction with overall health services, 81.9% said they were very satisfied or somewhat satisfied, compared to 84.6% for Canada. The difference between the NWT and Canada is not statistically significant.

Figure 9.1
Patient Rating of Quality of Overall Health Services
Percent Rating Excellent or Very Good



Source: Statistics Canada

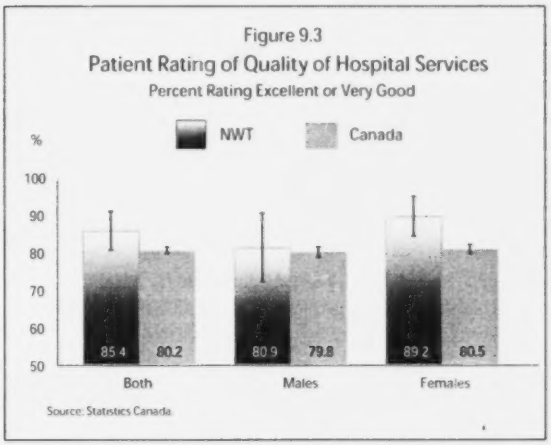
Figure 9.2
Patient Satisfaction with Overall Health Services Provided
Percent Reporting Very Satisfied or Somewhat Satisfied

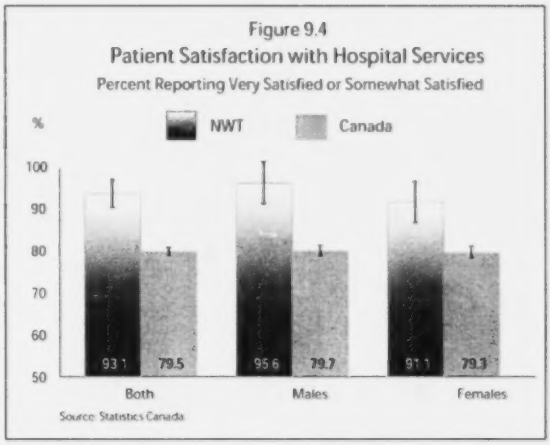


Source: Statistics Canada

As seen in Figure 9.3, 85.4% of the population in the NWT rated the quality of hospital services to be excellent or very good, compared to 80.2% of Canadians. The difference between the NWT and Canada is not statistically significant.

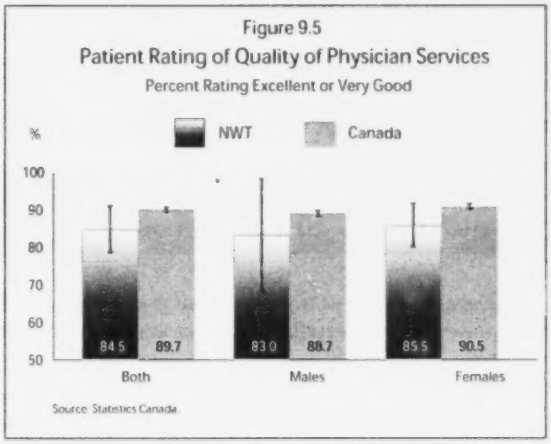
Figure 9.4 shows that when people in the NWT were asked to report their level of satisfaction with hospital services, 93.1% said they were very satisfied or somewhat satisfied, compared to 79.5% of Canadians. The difference between the NWT and Canada is statistically significant.

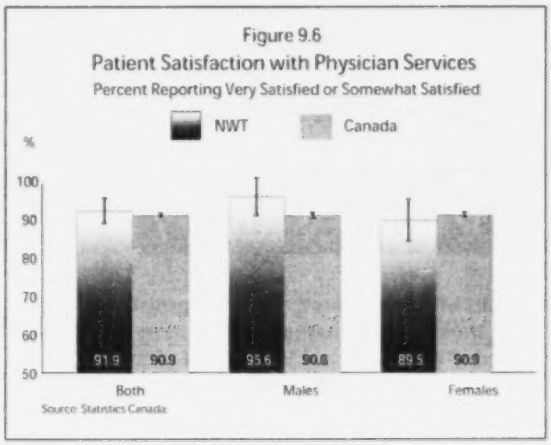




As seen in Figure 9.5, 84.5% of the NWT population rated the quality of physician services to be excellent or very good, compared to 89.7% of Canadians. The difference between the NWT and Canada is not statistically significant.

Figure 9.6 shows that when people in the NWT were asked to report their level of satisfaction with physician services, 91.9% said they were very satisfied or somewhat satisfied, compared to 90.9% of Canadians. The difference between the NWT and Canada is not statistically significant.





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As seen in Figure 9.1, 80.5% of the NWT population rated the quality of overall health services to be excellent or very good, compared to 84.4% of the Canadian population. The difference between the NWT and Canada is not statistically significant.

Figure 9.2 shows that when people in the NWT were asked to report their level of satisfaction with overall health services, 81.9% said they were very satisfied or somewhat satisfied, compared to 84.6% for Canada. The difference between the NWT and Canada is not statistically significant.

Figure 9.1
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Percent Rating Excellent or Very Good

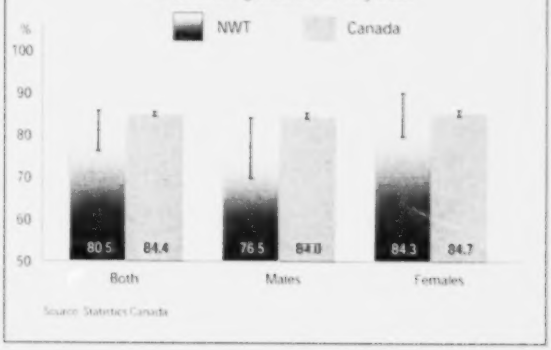
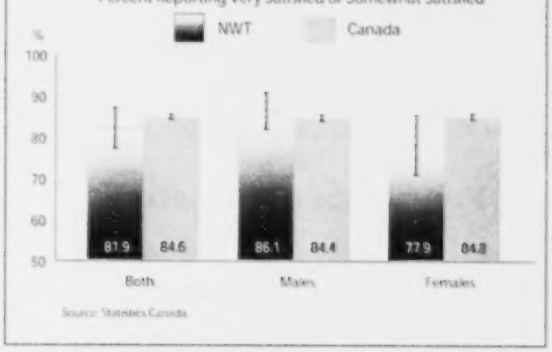


Figure 9.2
Patient Satisfaction with Overall Health Services Provided
Percent Reporting Very Satisfied or Somewhat Satisfied



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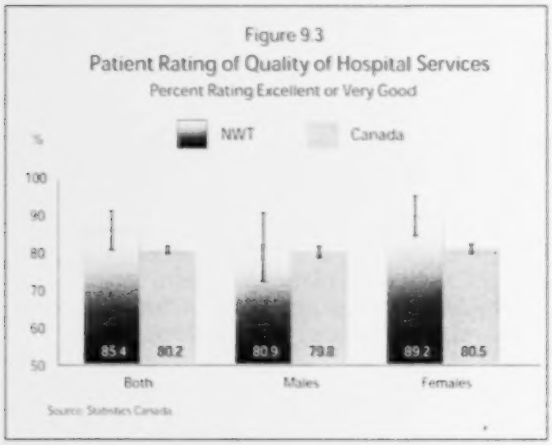

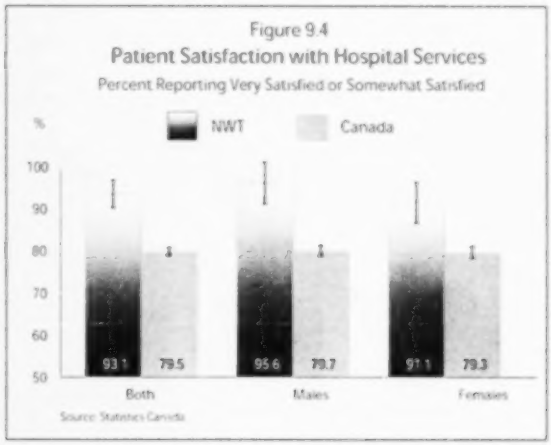

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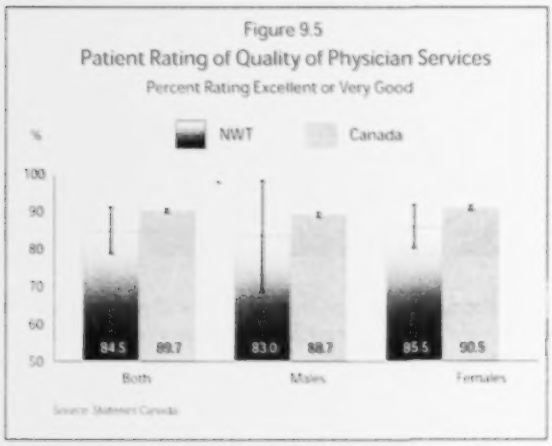
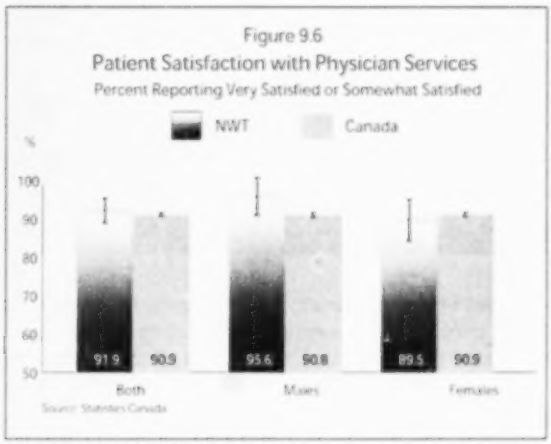
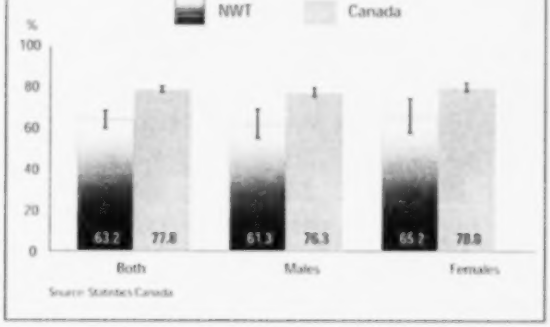




As seen in Figure 9.7, 63.2% of the NWT population rated the quality of community-based health services to be excellent or very good, compared to 77.8% of Canadians. The difference between the NWT and Canada is statistically significant.

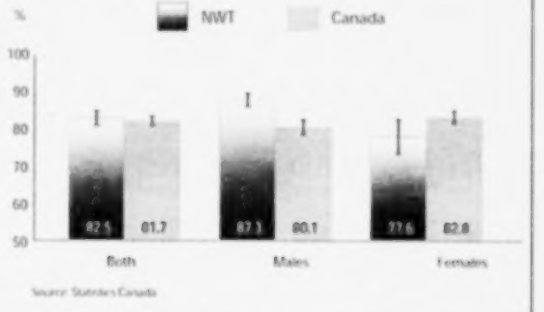
Figure 9.8 shows that when people in the NWT were asked to report their level of satisfaction with community-based health services, 82.5% said they were very satisfied or somewhat satisfied, compared to 81.7% of Canadians. The difference between the NWT and Canada is not statistically significant. For the NWT, there was a significant difference between the sexes, with 87.3% of males versus 77.6% of females reporting they were very satisfied or somewhat satisfied.

Figure 9.7
Patient Rating of Quality of Community-Based Health Services
Percent Rating Excellent or Very Good



Source: Statistics Canada

Figure 9.8
Patient Satisfaction with Community Based Health Services
Percent Reporting Very Satisfied or Somewhat Satisfied



Source: Statistics Canada

Quality of Service

10 Hospital re-admissions for selected conditions

Given the NWT's small population and consequent small numbers of admissions, the rates for these indicators are too small to report in a reliable manner.

11 Access to 24/7 first contact health services

The data for this indicator are not available for the NWT. The information comes from the special supplement of the Canadian Community Health Survey, which covers the provinces but not the NWT. In future years, the NWT is intended to be included in this part of the survey.

As seen in Figure 9.7, 63.2% of the NWT population rated the quality of community-based health services to be excellent or very good, compared to 77.8% of Canadians. The difference between the NWT and Canada is statistically significant.

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Figure 9.7
Patient Rating of Quality of Community-Based Health Services
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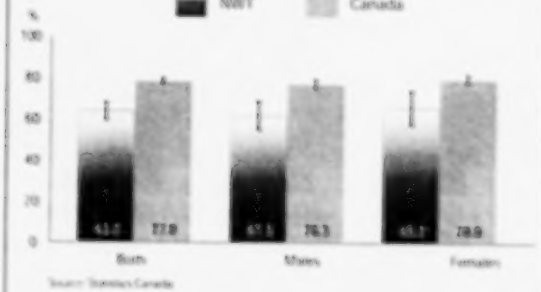
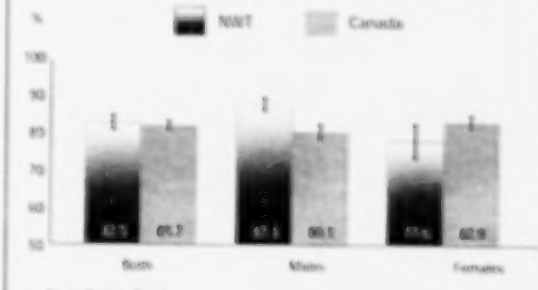


Figure 9.8
Patient Satisfaction with Community Based Health Services
Percent Reporting Very Satisfied or Somewhat Satisfied



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12 Home and community care services

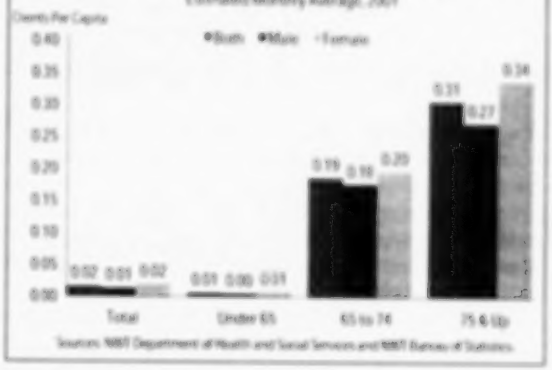
In recent years, governments have supported programs to deliver some health services to people in their homes as an alternative to admitting people to acute care or long term care facilities. This trend has certain benefits: people needing care are more comfortable, and their life styles and independence are maintained for as long as possible; facility space can be reserved for those with greater health care needs; and lower costs are often associated with home care, compared to care in institutions.

12a. Home care admissions

The numbers in Figure 12a are estimates based on a set of monthly reports submitted by NWT health and social services authorities. The numbers are based on averages of the client counts provided in these monthly reports. The reader should note that some communities often only report for part of the year. Given the nature of estimates, the data provided in this section and section 12b is subject to future revisions.

Home care is generally used by seniors, especially older seniors (ages 75 and over). The average per capita admissions (admissions divided by the population) for 2001 were 0.02. Meaning that, on average 2% of NWT residents were admitted to a home care service in the NWT in 2001.[*] By sex, approximately 1% of males were admitted, compared with 2% of females.

Figure 12a
Admissions to Publicly Funded Home Care Services Per Capita
Estimated Monthly Average, 2001



Sources: NWT Department of Health and Social Services and NWT Bureau of Statistics

12b. Home care admissions, age 75 & up

As seen in Figure 12a, the proportion of the NWT population receiving a home care service rises dramatically with age. On average, 0.31 (or 31%) residents age 75 and over on a per capita basis were admitted to a home care service. When examined by sex, the figure varies considerably, with 27% of the male population, compared to 34% of the female population, being admitted for a home care service.

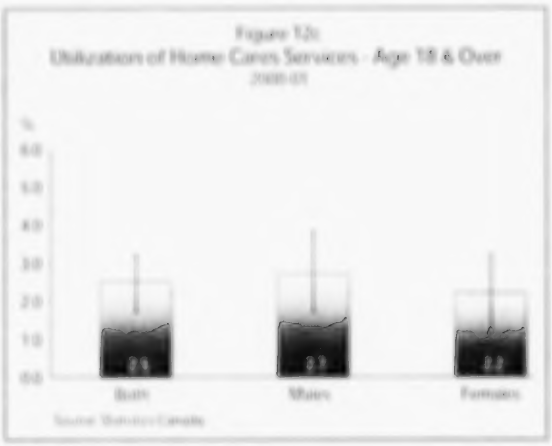
12c. Utilization of home care services

In contrast to indicators 12a and 12b, indicator 12c looks at the utilization of home care services and relies on the CCHS as the data source. The CCHS for 2000-01 asked individuals aged 18 and over whether they had received one or more of the following home care services: homemaking, nursing or respite (care when the regular care given is absent) services.

[*] NWC reporting requirements mandate that admission data be expressed in per capita terms.

Figure 12c shows that 2.5% of the population age 18 and over utilized a home care service in 2000-01.

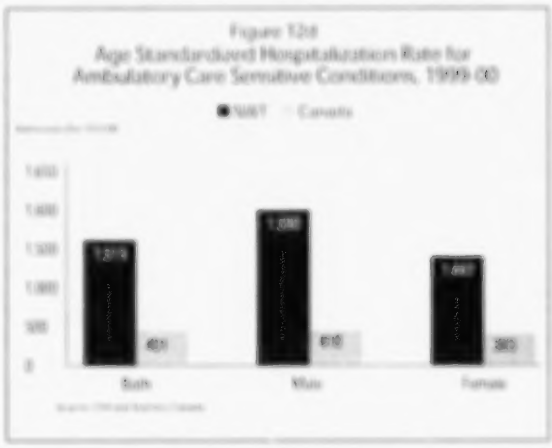
CCHS data for this indicator are too small to report for all age groups. However, as seen in Table 12c (Appendix B), utilization of home care services by the population age 65 and over can be reported. Approximately 20% of the NWT senior population utilized a home care service. The CV is high, at 20.5, for the results of this age group, and thus should be treated with caution.



12d. Ambulatory care sensitive conditions (ACSC)

The hospitalization rate for ambulatory care sensitive conditions (ACSC) - conditions that may often be cared for in the community - is one indicator of appropriate access to community based care. These are long-term health care conditions that can often be managed with timely and effective treatment in the community, without hospitalization. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression, hypertensive disease and others. Although preventive care, primary care, and community-based management of these conditions will not eliminate all hospitalizations, such steps could eliminate many of them.

The data for this indicator is only available for the NWT for 1999-00.[1] The age-standardized rate for ACSC for the NWT was 1,513 hospitalizations per 100,000. For males, the rate was 1,590 per 100,000, and for females, 1,447 per 100,000.



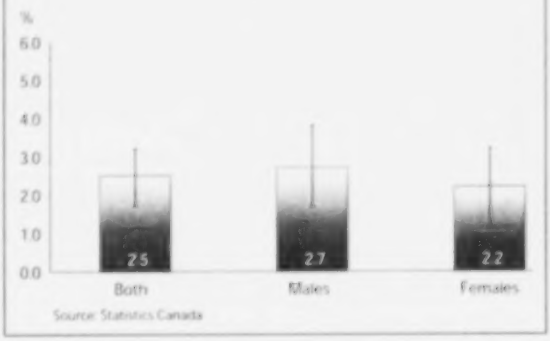
For comparison, the overall Canadian rate was 401 hospitalizations per 100,000 population. The differences between the NWT and Canada, for ACSC, are statistically significant for both sexes combined, and each sex, separately.

[1] In years previous to 1999/00, Nunavut data was combined with NWT data. The data for this indicator come from the Canadian Institute for Health Information (CIHI), and Statistics Canada.

Figure 12c shows that 2.5% of the population age 18 and over utilized a home care service in 2000-01.

CCHS data for this indicator are too small to report for all age groups. However, as seen in Table 12c (Appendix B), utilization of home care services by the population age 65 and over can be reported. Approximately 20% of the NWT senior population utilized a home care service. The CV is high, at 20.5, for the results of this age group, and thus should be treated with caution.

Figure 12c
Utilization of Home Cares Services - Age 18 & Over
2000-01

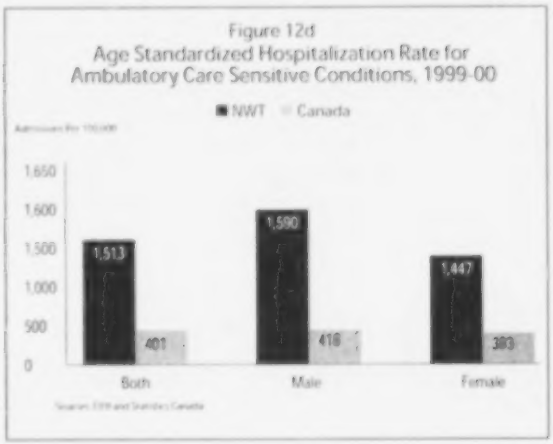


Source: Statistics Canada

12d. Ambulatory care sensitive conditions (ACSC)

The hospitalization rate for ambulatory care sensitive conditions (ACSC) - conditions that may often be cared for in the community - is one indicator of appropriate access to community based care. These are long-term health care conditions that can often be managed with timely and effective treatment in the community, without hospitalization. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression, hypertensive disease and others. Although preventive care, primary care, and community-based management of these conditions will not eliminate all hospitalizations, such steps could eliminate many of them.

Figure 12d
Age Standardized Hospitalization Rate for
Ambulatory Care Sensitive Conditions, 1999-00



The data for this indicator is only available for the NWT for 1999-00.[1] The age-standardized rate for ACSC for the NWT was 1,513 hospitalizations per 100,000. For males, the rate was 1,590 per 100,000, and for females, 1,447 per 100,000.

For comparison, the overall Canadian rate was 401 hospitalizations per 100,000 population. The differences between the NWT and Canada, for ACSC, are statistically significant for both sexes combined, and each sex, separately.

[1] In years previous to 1999/00, Nunavut data was combined with NWT data. The data for this indicator come from the Canadian Institute for Health Information (CIHI) and Statistics Canada.

13 Public health surveillance and protection[18]

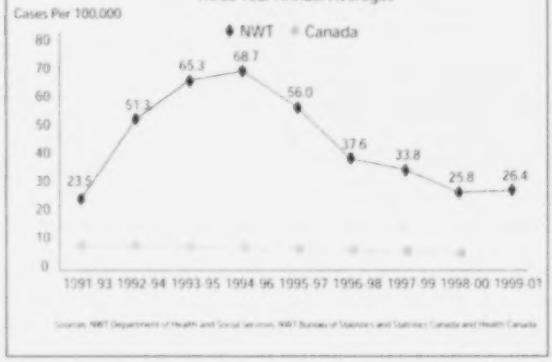
Four notifiable diseases are reported on in this section (tuberculosis, HIV, verotoxogenic *E.Coli*, and chlamydia) as well as self-reported exposure to environmental tobacco smoke. These four diseases provide a representative sample of diseases covering the four areas of water borne diseases, food borne diseases, airborne diseases, and diseases that are transmitted sexually or through intravenous drug use. Self-reported exposure to environmental tobacco smoke reflects the effectiveness of the public health system in protecting non-smokers against exposure to tobacco smoke in public spaces and work places.

13a. Tuberculosis (Pulmonary)[19]

Tuberculosis (TB) is an important public health problem that has become more prominent in recent years. The incidence of TB is linked to high-risk groups such as recent immigrants, First Nations communities and people infected with HIV. Multiple drug resistance is also emerging as a problem.

TB cases are few in actual numbers in the NWT. Between 1991 and 2001, there were 172 reported cases of pulmonary TB in the NWT, or approximately 16 reported cases per year.

Figure 13a
Tuberculosis (Pulmonary) Incidence Rate
Three Year Annual Averages



As can be seen in Figure 13a, in the NWT between 1991-93 there were an average of 23.5 cases of pulmonary TB per 100,000 population, and an average of 26.4 cases per 100,000 between 1999-01. By comparison, in Canada the average was 7.2 cases per 100,000 between 1991-93, and 5.8 cases per 100,000 between 1998-00. The difference between the NWT and Canada, for TB, is statistically significant for 1998-00.

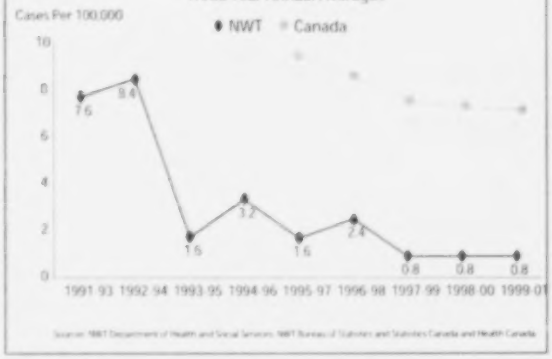
In total between 1991 and 2001 there have been 172 cases of pulmonary TB reported in the NWT.

13b. HIV

Most HIV infections are sexually transmitted, making the rate of HIV infections a possible indicator of high-risk sexual behaviours. In general, the rate of decline of new HIV infections has slowed or perhaps reversed in Canada. In the NWT, however, it is very difficult to provide a trend for HIV due to small numbers.

Figure 13b shows the incidence of HIV infections. In the NWT there were an average of 7.6 new cases per 100,000 between 1991-93, and between 1999-01 the average number of new cases was 0.8 per 100,000. By comparison, the average number of new cases of HIV infection in Canada between 1999-01 was 7.1 per 100,000 population. The difference between the NWT and Canada, for HIV, is not statistically significant for 1999-01.

Figure 13b
HIV Incidence Rate
Three Year Annual Averages



In total between 1991 and 2001 there have been 15 cases of HIV reported in the NWT.

[18] NWT data for the Indicators 13a to 13d came from the NWT Department of Health and Social Services (diseases), NWT Bureau of Statistics and Statistics Canada (population estimates). Canadian data came from Health Canada (diseases) and Statistics Canada (population estimates). NWT data for Indicators 13a, 13c and 13d are subject to future revisions. Canadian data for for Indicator 13a are preliminary for year 2000, and subject to revision; and Canada data for Indicators 13c and 13d are preliminary for the years 2000 and 2001, and are subject to future revision.

[19] Only pulmonary (lung specific) TB is included, as mandated by PIRC reporting requirements.

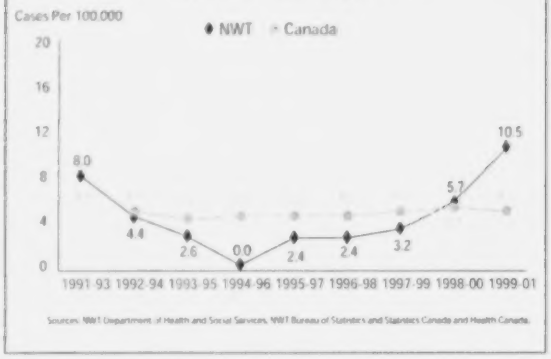
13c. Verotoxogenic *E. coli*[20]

Verotoxogenic *E.coli* may be considered an approximate indicator of food-borne illness.

As can be seen in Figure 13c, in the NWT between 1991-93 there were an average of 8 cases of E. coli per 100,000 population, and an average of 10.5 cases per 100,000 between 1999-01. The Canadian rate averaged 4.7 cases per 100,000 between 1992-94, and 4.9 cases per 100,000 between 1999-01. The difference between the NWT and Canada, for E Coli, is not statistically significant 1999-01.

In total between 1991 and 2001 there have been 25 cases of E. coli reported in the NWT.

Figure 13c
Verotoxogenic *E Coli* Incidence Rate
Three Year Annual Averages



Sources: NWT Department of Health and Social Services, NWT Bureau of Statistics and Statistics Canada and Health Canada.

13d. Chlamydia

Chlamydia is a common sexually transmitted disease (STD), which may result in female infertility and ectopic pregnancy. The higher incidence rates relative to other STDs indicate chlamydia is a more sensitive indicator of change in risk behaviours and reflects the effectiveness of primary and secondary prevention programs.

Unlike TB, HIV, and *E.Coli*, there are a large number of cases of chlamydia each year in the NWT. Most of these cases occur in the population age 15 to 24, and are also more prevalent amongst women than men.

As seen in Figure 13d.1, the rate of chlamydia has increased from 1,049.2 cases per 100,000 in 1991-93 to 1,166.8 cases per 1,000 in 1999-01. The chlamydia rate dips in the mid 1990s, and then increases steadily after 1995-97. By comparison, the average incidence of chlamydia in the Canadian population between 1999-01 was 150.1 cases per 100,000 population. The difference between the NWT and Canada, for Chlamydia, is statistically significant 1999-01.

The rate of chlamydia in females has decreased somewhat between 1991-93 and 1999-01. As seen in Figure 13d.2 the rate was 1,712.6 cases per 100,000 in 1991-93, dropping to 1,478.3 per 100,000 by 1995-97,[21] and then trending upwards to 1,683.3 per 100,000 in 1991-01. For males, the trend has been a steady increase across the eleven-year period, from 450.2 to 685.1 cases per 100,000.

Figure 13d.1
Chlamydia Incidence Rate
Three Year Annual Averages

Figure 13d.2
Chlamydia Incidence Rate
Three Year Annual Averages, NWT

[20] Verotoxogenic *E. Coli* is a food and water borne disease which can cause extreme illness, and in some cases, death.
[21] A new diagnostic test introduced around 1997 (nucleic acid amplification test or NAAT) may have initially accounted for some of the increase in incidence. However, since the incidence of chlamydia has continued to increase, it can be assumed there are actually more cases now, and we are no longer seeing the effect of the new test.

Figure 13d.3 shows the incidence rate of chlamydia for the two highest risk groups, by age. Between 1991-93 and 1999-01, the rate for 15-19 years olds increased from 4,340.2 to 5,214.5 cases per 100,000. And, for the 20-24 year olds, the rate increased from 4,120.5 to 4,702.3 cases per 100,000, over the same time frame.

Figure 13d.4 shows the incidence rate of chlamydia for the 15 to 19 years olds by sex. On average, females of this age group have a rate of chlamydia six times higher than males of the same age group. For both sexes, the rates have increased between 1991-93 and 1999-01.

Figure 13d.3
Chlamydia Incidence Rate - Age 15 to 19 and Age 20 to 24
Three Year Annual Averages, NWT

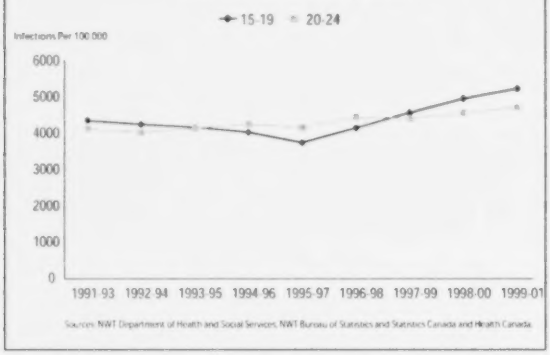


Figure 13d.4
Chlamydia Incidence Rate - 15 to 19 year olds
Three Year Annual Averages, NWT

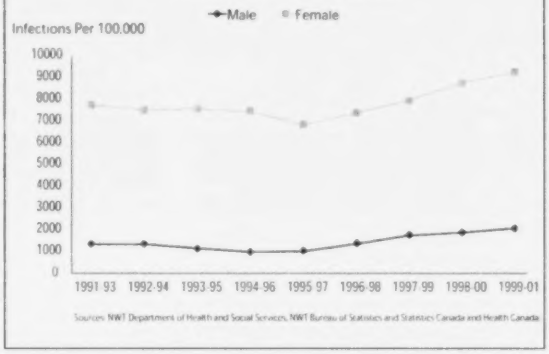
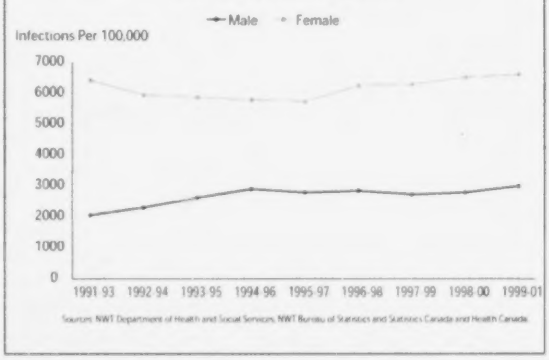


Figure 13d.5 provides the incidence rate of chlamydia for the 20 to 24 year olds by sex. The gap between men and women narrows somewhat in comparison to the 15-19 year old segment. However, women are still significantly more at risk, with their rates being 2.5 times higher than the male population. In Figure 13d.5, the rate has increased for both sexes between 1991-93 and 1999-01. The increase for women (6,361.6 to 6,550.2 cases per 100,000) has been relatively marginal when compared to men (1,985.9 to 2,925.5 cases per 100,000).

Figure 13d.5
Chlamydia Incidence Rate - 20 to 24 year olds
Three Year Annual Averages, NWT

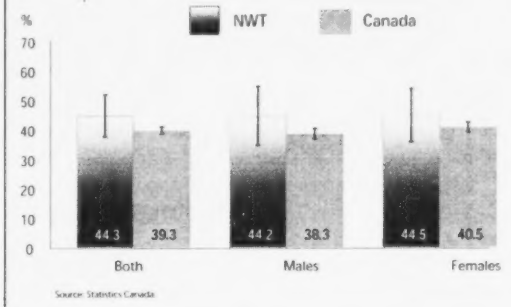


13e. Exposure to environmental tobacco smoke

The relationship between environmental tobacco smoke (ETS) and adverse health effects is well documented. Besides being a known mucous membrane irritant, second-hand smoke exposure is linked to increases in mortality from lung cancer and cardiovascular disease. Second-hand smoke has serious consequences for children: smoking mothers bear children with lower birth weights, and children living in homes where they are exposed to tobacco smoke have higher rates of asthma and respiratory tract problems. And, in general, there is strong evidence of an association between exposure to environmental tobacco smoke and respiratory illness.

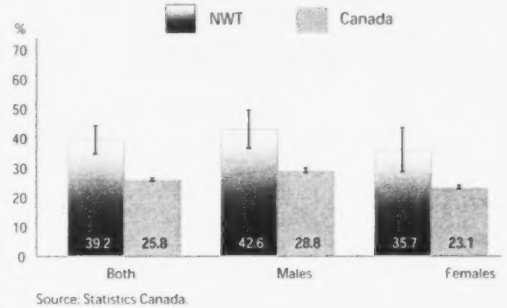
The CCHS asked survey respondents, who were non-smokers, about their exposure to environmental tobacco smoke in the previous month to being surveyed. Figure 13e.1 shows that 44.3% of 12 to 19 year old surveyed in the NWT had exposure to ETS, compared to 39.3% of Canadians. The difference between the NWT and Canada, for age 12 to 19, is not statistically significant. Figure 13e.2 shows that 39.2% of the population 20 years and older in the NWT had exposure to ETS, compared to 25.8% of Canadians. The difference between the NWT and Canada, for age 20& over, is statistically significant.

Figure 13e.1
Exposure to Environmental Tobacco Smoke
Age 12 to 19, 2000-01



Source: Statistics Canada

Figure 13e.2
Exposure to Environmental Tobacco Smoke
Age 20 & Up, 2000-01



Source: Statistics Canada

14 Health promotion and disease prevention

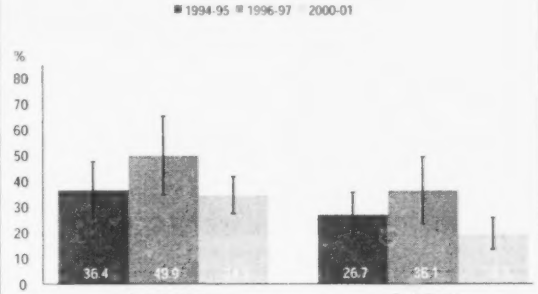
14a. Smoking

Tobacco use is a leading cause of preventable illness and death. Most lifelong smokers in the NWT started smoking by the time they were 18 years old.[22]

Figure 14a.1 shows the percentage of the population age 12 to 19, at the time of survey, that were current smokers (daily or occasional) and daily smokers. The proportion of both current and daily smokers has moved up and down over the three surveys.[23] Yet, the differences between the results of each survey are not statistically significant. One of the problems evident here is in the small sample sizes of the 1994-95 and 1996-97 surveys. In each case, the reader should interpret the results with caution. In contrast, the 2000-01 survey had a larger sample, and the results have narrower confidence intervals and lower CVs than the earlier two surveys.

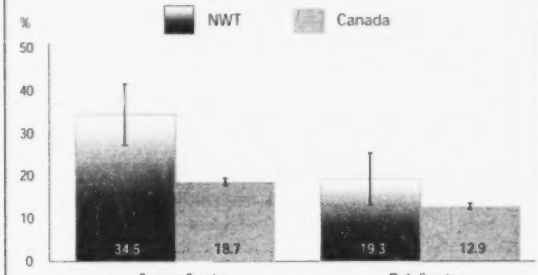
In 2000-01, almost 35% of 12 to 19 year olds were reported to be current smokers, with 19% being daily smokers, compared to 18.7% and 12.9% respectively for 12 to 19 year old Canadian youth. The difference between the NWT and Canada, for current smokers, is statistically significant. However, the difference between the NWT and Canada, for daily smokers, is not statistically significant.

Figure 14a.1
Smokers by Type - Age 12 to 19



Source: Statistics Canada.

Figure 14a.2
Smokers by Type - Age 12 to 19
2000-01



Source: Statistics Canada.

14b. Physical activity

Physical activity is associated with a range of health benefits. Many studies have shown that regular physical activity confers major heart health benefits and that inactivity is a major risk factor for heart disease. Recent evidence from the National Population Health Survey supports this conclusion, and also shows that physically active individuals are less likely to become depressed.

Figure 14b.1 shows the results from three surveys for proportion of the population, age 12 and over, that were moderately active or active.[24] People were asked a series of questions about their engagement in physical activity, and their responses were used to calculate an index of physical activity. In 1994-95, 47.1% of the population in the NWT was moderately active or active, dropping in 2000-01 to 38.4%. This drop was largest amongst the male population, 50.6% to 37.2%. The drop in activity levels of the total population between 1994-95 and 2000-01 is statistically significant.[25] The drop for males in activity is also statistically significant. However, the drop for females is not statistically significant.

[22] *Smoke Alarm*, April 2001, Department of Health and Social Services.
[23] Statistics Canada, 1994/95 and 1996/97 National Population Health Survey; Statistics Canada, 2000-01 Canadian Community Health Survey

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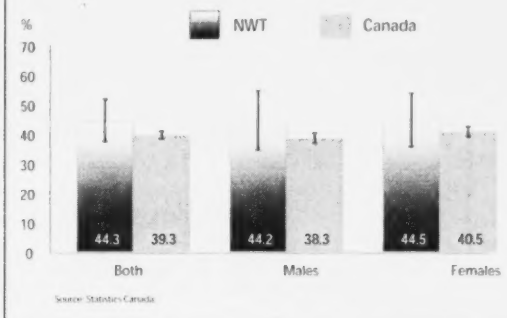
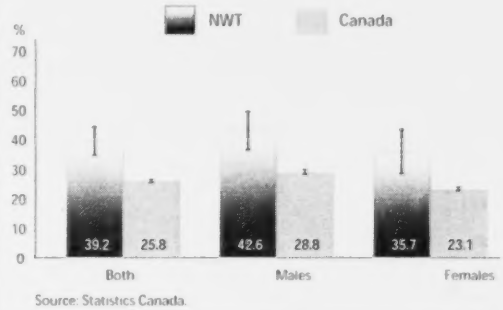
Exposure to Environmental Tobacco Smoke
Age 12 to 19, 2000-01



Source: Statistics Canada

Figure 13e.2
Exposure to Environmental Tobacco Smoke
Age 20 & Up, 2000-01



Source: Statistics Canada.

14 Health promotion and disease prevention

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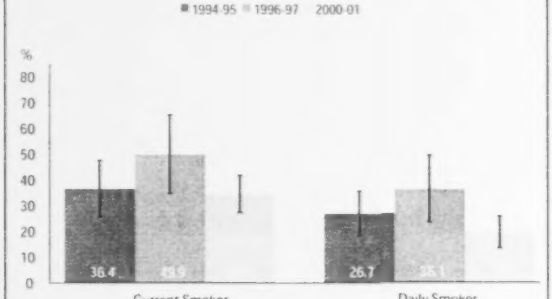
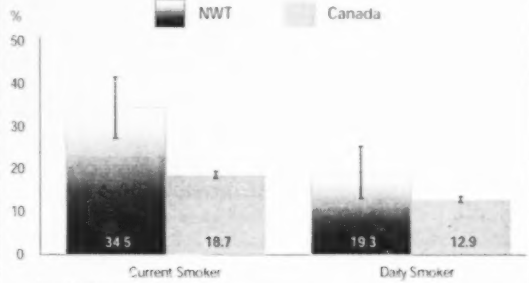


Source: Statistics Canada.

Figure 14a.2
Smokers by Type - Age 12 to 19
2000-01



Source: Statistics Canada

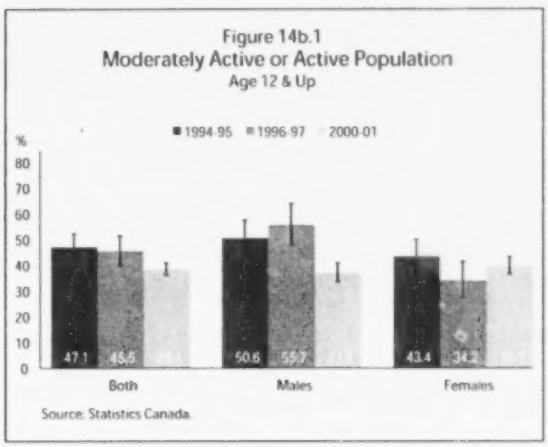
14b. Physical activity

Physical activity is associated with a range of health benefits. Many studies have shown that regular physical activity confers major heart health benefits and that inactivity is a major risk factor for heart disease. Recent evidence from the National Population Health Survey supports this conclusion, and also shows that physically active individuals are less likely to become depressed.

Figure 14b.1 shows the results from three surveys for proportion of the population, age 12 and over, that were moderately active or active.[24] People were asked a series of questions about their engagement in physical activity, and their responses were used to calculate an index of physical activity. In 1994-95, 47.1% of the population in the NWT was moderately active or active, dropping in 2000-01 to 38.4%. This drop was largest amongst the male population, 50.6% to 37.2%. The drop in activity levels of the total population between 1994-95 and 2000-01 is statistically significant.[25] The drop for males in activity is also statistically significant. However, the drop for females is not statistically significant.

[22] *Smoke Alarm*, April 2001, Department of Health and Social Services.
[23] Statistics Canada, 1994/95 and 1996/97 National Population Health Survey; Statistics Canada, 2000-01 Canadian Community Health Survey.

Figure 14b.2 provides a 2000-01 comparison of NWT and Canada residents by age considered to be moderately active or active. Statistically significant differences, between the NWT and Canada, occur for youth, age 12 to 19, and for adults age 45 to 64. In both cases, these age groups in the NWT had lower levels of activity than their national peers.



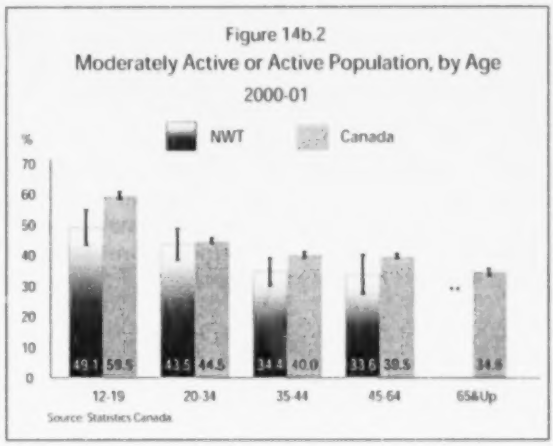
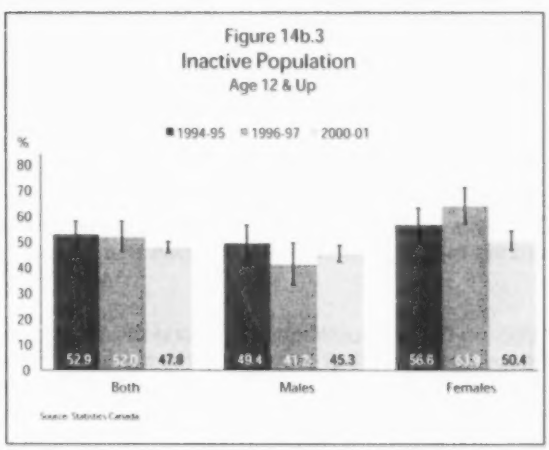
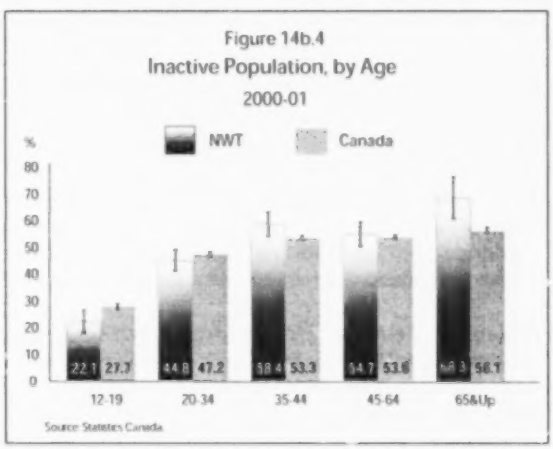


Figure 14b.3 shows the proportion of the population considered to be inactive from the three surveys. In 1994/95, 52.9% of the population in the NWT was considered to be inactive, compared to 47.8% in 2000-01. The drop in inactivity is not significant. For females, there is a statistically significant drop between 1996-97 and 2000-01, from 63.9% to 50.4% being inactive. Of note is the fact that the 2000-01 results had a large proportion (approximately 14%) of those surveyed not answer the questions on physical activity. In contrast, the non-response rates for the 1994-95 and 1996-97 surveys were so small that the values had to be suppressed.

Figure 14b.4 provides a 2000-01 comparison of NWT and Canada residents by age considered to be inactive. Statistically significant differences, between the NWT and Canada, occur for youth, age 12 to 19, and for adults age 35 to 44, and for seniors 65 and over. NWT residents age 35 to 44, and 65 and up, had higher levels of inactivity than their national peers. However, youth, 12 to 19, had lower levels of inactivity than youth nationally.



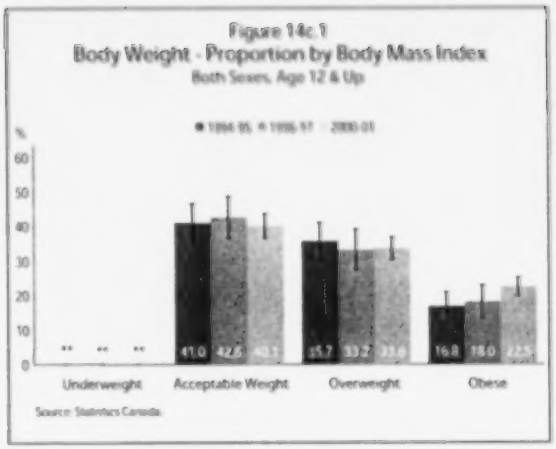


[*] Statistics Canada, 1994/95 and 1996/97 National Population Health Surveys, Statistics Canada, 2000-01 Canadian Community Health Survey
[**] It should be noted that the 2000-01 survey was based on a different sample than previous two surveys. The difference noted may be due to differences in sampling techniques rather than actual levels.

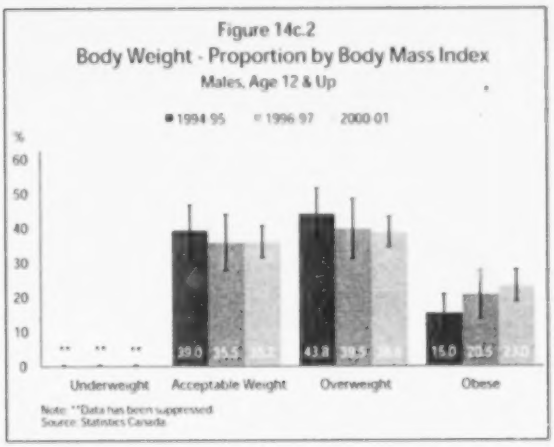
14c. Body weight

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart diseases. The Body Mass Index (BMI) is the most common method of determining if an individual's weight is in a healthy range. The BMI is based on self-reported height and weight, and calculated for people age 20 to 64 year olds, excluding pregnant women.[26]

Figure 14c.1 shows the proportion of the NWT population's BMI by four categories: underweight, acceptable weight, overweight and obese. There has not been a significant change over the three survey years, in any one of the BMI categories.



Figures 14c.2 and 14c.3 show the BMI by proportion of the NWT male and female population, respectively. There has not been a significant change over the three years for either sex, in any one of the BMI categories.



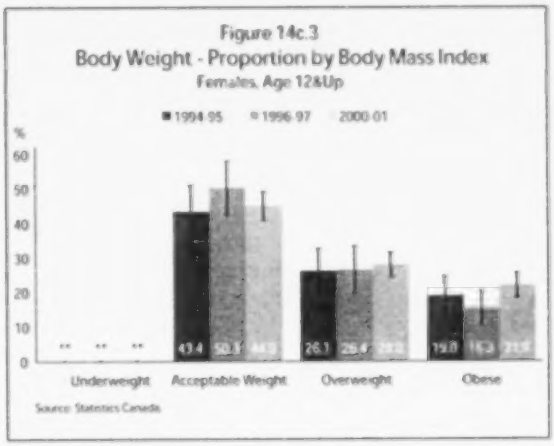
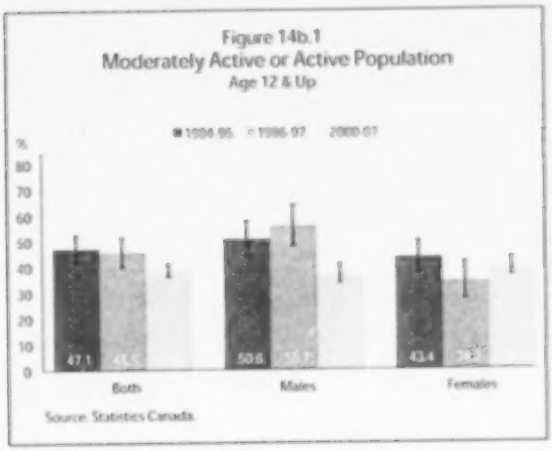


Figure 14c.4 compares the proportion of the population overweight in the NWT to Canada by age group. There are not any significant differences in the proportion of the population overweight between the NWT and Canada across age groups.

Figure 14c.5 compares the proportion of the population obese in the NWT to Canada by age group. Across all three age groups, the NWT had a significantly higher proportion of the population, compared to Canada, considered to be obese: 17.3% vs 11.3% for 20 to 34 year olds; 20.9% vs 14.7% for 35 to 44 year olds, and 31.2% vs 18.2% for 45 to 64 year olds.

*Due to different rates of growth for individuals under 20 years of age, the standard BMI is not considered a suitable indicator for this group. Given results are based on self-reported height and weight, individuals may not always report reliably.

Figure 14b.2 provides a 2000-01 comparison of NWT and Canada residents by age considered to be moderately active or active. Statistically significant differences, between the NWT and Canada, occur for youth, age 12 to 19, and for adults age 45 to 64. In both cases, these age groups in the NWT had lower levels of activity than their national peers.



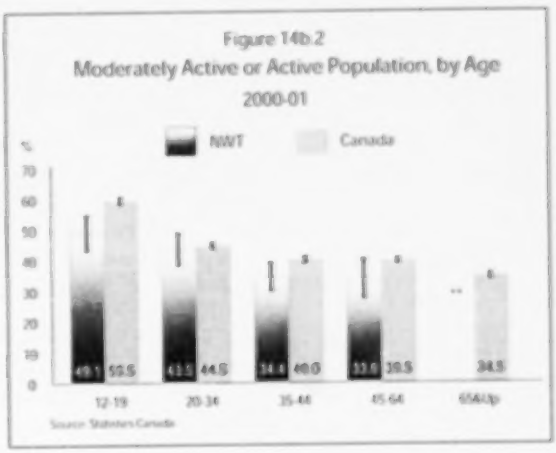
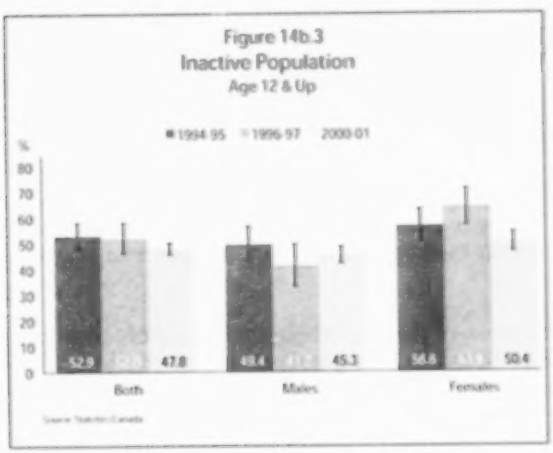
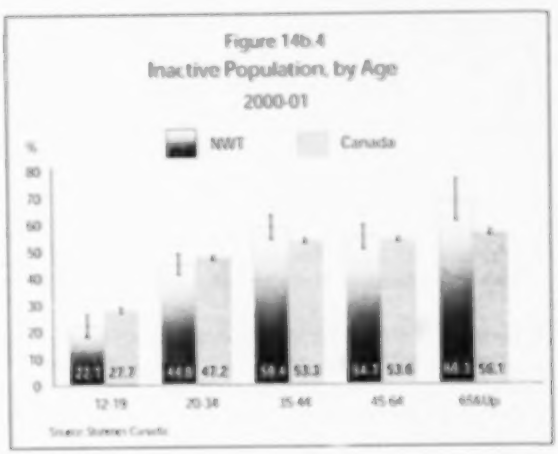


Figure 14b.3 shows the proportion of the population considered to be inactive from the three surveys. In 1994/95, 52.9% of the population in the NWT was considered to be inactive, compared to 47.8% in 2000-01. The drop in inactivity is not significant. For females, there is a statistically significant drop between 1996-97 and 2000-01, from 63.9% to 50.4% being inactive. Of note is the fact that the 2000-01 results had a large proportion (approximately 14%) of those surveyed not answer the questions on physical activity. In contrast, the non-response rates for the 1994-95 and 1996-97 surveys were so small that the values had to be suppressed.

Figure 14b.4 provides a 2000-01 comparison of NWT and Canada residents by age considered to be inactive. Statistically significant differences, between the NWT and Canada, occur for youth, age 12 to 19, and for adults age 35 to 44, and for seniors 65 and over. NWT residents age 35 to 44, and 65 and up, had higher levels of inactivity than their national peers. However, youth, 12 to 19, had lower levels of inactivity than youth nationally.





* Statistics Canada, 1994/95 and 1996/97 National Population Health Surveys; Statistics Canada, 2000-01 Canadian Community Health Survey
** It should be noted that the 2000-01 survey was based on a different sample than previous two surveys. The difference noted may be due to differences in sampling techniques rather than actual levels.

14c. Body weight

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart diseases. The Body Mass Index (BMI) is the most common method of determining if an individual's weight is in a healthy range. The BMI is based on self-reported height and weight, and calculated for people age 20 to 64 year olds, excluding pregnant women.[25]

Figure 14c.1 shows the proportion of the NWT population's BMI by four categories: underweight, acceptable weight, overweight and obese. There has not been a significant change over the three survey years, in any one of the BMI categories.

Figures 14c.2 and 14c.3 show the BMI by proportion of the NWT male and female population, respectively. There has not been a significant change over the three years for either sex, in any one of the BMI categories.

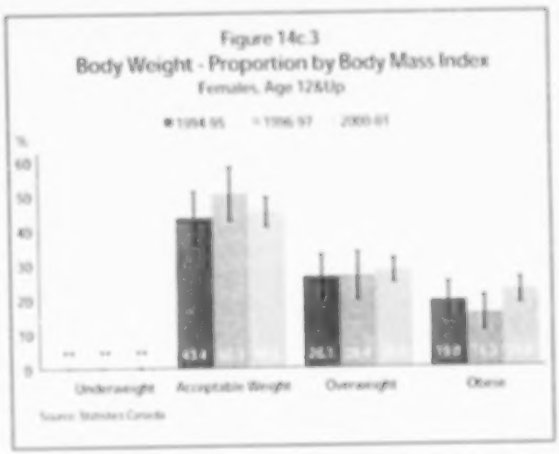
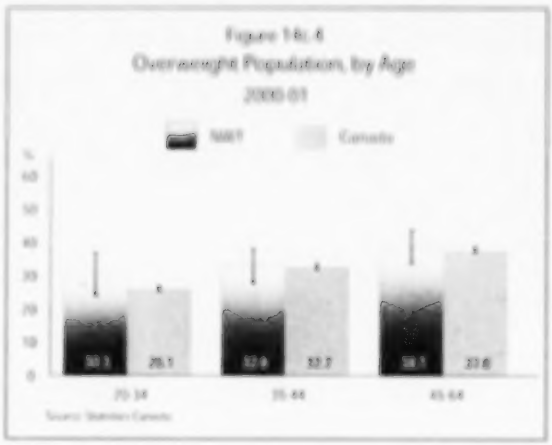
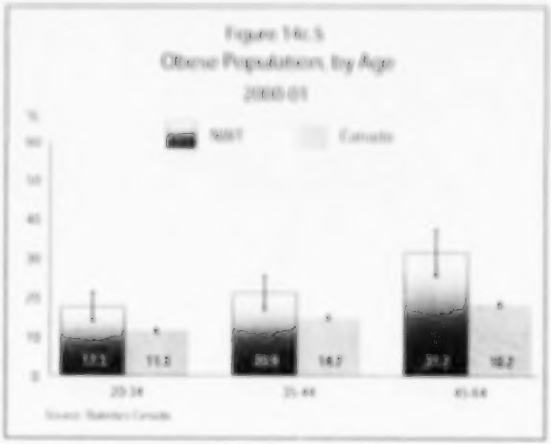


Figure 14c.4 compares the proportion of the population overweight in the NWT to Canada by age group. There are not any significant differences in the proportion of the population overweight between the NWT and Canada across age groups. *

Figure 14c.5 compares the proportion of the population obese in the NWT to Canada by age group. Across all three age groups, the NWT had a significantly higher proportion of the population, compared to Canada, considered to be obese: 17.3% vs 11.3% for 20 to 34 year olds; 20.9% vs 14.7% for 35 to 44 year olds, and 31.2% vs 18.2% for 45 to 64 year olds.

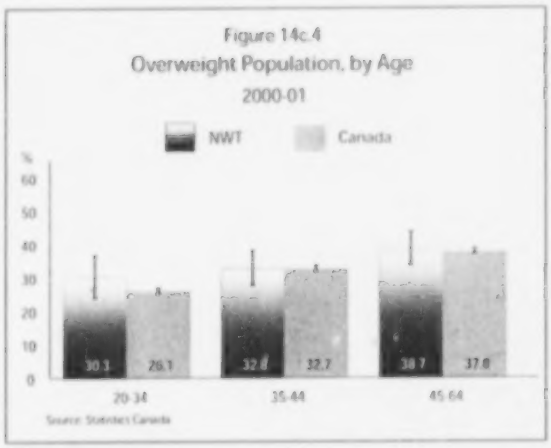
* Due to different rates of growth for individuals under 20 years of age, the standard BMI is not considered a suitable indicator for this group. Given results are based on self-reported height and weight, individuals may not always report reliably.

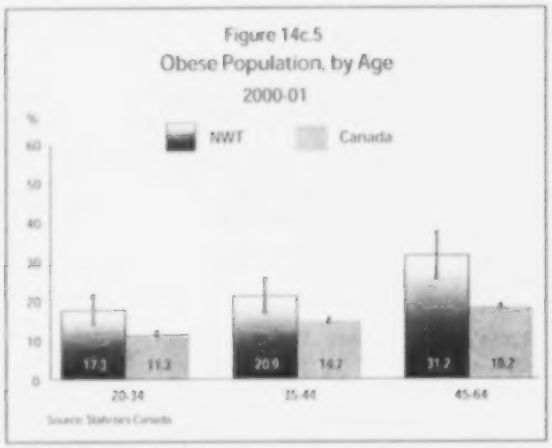




14d. Immunization for influenza for the population age 65 & up

Data for this indicator were not available for the NWT. While the question was asked of NWT residents during the 2000-01 CCHS, the results were based on a sample too small to report on for the population age 65 and up.





14d. Immunization for influenza for the population age 65 & up

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Conclusion

This report offers one perspective on the health of the people of the Northwest Territories, and on their health care system. It is a report that fulfills a commitment made by First Ministers to provide regular reporting to Canadians on health status, health outcomes and quality of health care services. The indicators selected for this report were chosen by the National Performance Indicators Reporting Committee in consultation with the provinces and territories, and are intended to provide a comparable set of data across the country.

The reader is cautioned against drawing too many conclusions from this first report. Although the data are presented in a standardized fashion, the relatively low numbers of actual cases of specific diseases, and the relatively small sample sizes for survey data, can make it difficult to draw meaningful comparisons. Furthermore, the fact that the data series generally only begin in 1990 makes it hard to detect trends at this time.

Overall, the report provides a strong case for the need to maintain health promotion and disease prevention initiatives. While there are many positive findings, there are also many challenges still to be overcome.

It is the intention to prepare a similar report every two years. This will supplement the NWT Health Status Report, and the NWT Health Services Report, which are published on a three-year cycle. Taken together, these reports reflect a commitment to keeping the people of the NWT well informed about the health are system and its impact on their health and well being.

Appendix A
First Minister's Meeting Communique on Health

NEWS RELEASE

First Ministers' Meeting
Ottawa, Ontario - September 11, 2000

FIRST MINISTERS' MEETING
COMMUNIQUÉ ON HEALTH

OTTAWA - September 11, 2000.

Nothing in this document shall be construed to derogate from the respective governments' jurisdictions. The Vision, Principles, Action Plan for Health System Renewal, Clear Accountability, and Working Together shall be interpreted in full respect of each government's jurisdiction.

Vision

First Ministers' vision of health is that:

Canadians will have publicly funded health services that provide quality health care and that promote the health and well-being of Canadians in a cost-effective and fair manner.

First Ministers believe that the key goals of the health system in Canada are to: preserve, protect and improve the health of Canadians; ensure that Canadians have reasonably timely access to an appropriate, integrated, and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and, ensure its long-term sustainability so that health care services are available when needed by Canadians in future years.

It will, therefore, provide greater integration of hospital, primary, home and community care, more emphasis on health protection and promotion, and more effective information sharing within and across jurisdictions.

First Ministers are committed to strengthening and renewing Canada's publicly funded health care services through partnership and collaboration. Given their constitutional responsibilities, provincial and territorial governments play the primary role in the design, management and funding of the health services within their jurisdictions.

Principles

To achieve these goals, *First Ministers make the following commitments* on health. Their governments will:

- support the principles of universality, accessibility, comprehensiveness, portability and public administration for insured hospital and medical services;
- continue to renew health care services by working with other governments, communities, service providers, and Canadians;
- promote those public services, programs and policies which extend beyond care and treatment and which make a critical contribution to the health and wellness of Canadians;
- further address key priorities for health care renewal and support innovations to meet the current and emerging needs of Canadians;
- expand the sharing of information on best practices and thereby contribute to continuing improvements in the quality and efficiency of their health care services;

- report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services, and the actions taken to improve these services; and,

- work in collaboration with Aboriginal people, their organizations and governments, to improve their health and well being.

Action Plan for Health System Renewal

Building on renewal initiatives already underway, First Ministers agree to collaborate on the following specific priorities so that each government can be more effective in relation to its responsibilities for health:

1. Access to Care

Provincial and Territorial Governments agree to work to improve both the timely access to, and quality of, health services of highest priority to Canadians.

2. Health Promotion and Wellness

All governments are engaged in health education and strategies to prevent illness. *First Ministers are committed* to strengthening their investments and commitments in this area, including the development of strategies and policies that recognize the determinants of health, enhance disease prevention and improve public health. This will support the shared priority of early childhood development.

3. Appropriate Health Care Services - Primary Health Care

All jurisdictions have had success with innovative models of renewed primary health care, resulting in better health outcomes, improved access, more satisfied providers, and the relief of pressures elsewhere in the health system, e.g., emergency rooms. *First Ministers agree* that improvements to primary health care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings.

First Ministers will continue to make primary health care reform a high priority. They agree to accelerate primary health care renewal. In particular, they agree to work towards ensuring timely access to services outside of expensive emergency departments.

Recognizing the need for flexibility and taking into account the particular needs and circumstances within jurisdictions, *First Ministers agree* to promote the establishment of interdisciplinary primary health care teams that provide Canadians first contact with the health care system. Such teams would also focus on health promotion, the prevention of illness and injury, and improved management of chronic disease. *First Ministers agree* that their governments will work together, in concert with health professionals, on improving primary health care and its integration with other components of the health care system.

4. Supply of Doctors, Nurses and other Health Personnel

Provinces and Territories agree on the objective of ensuring that each government or jurisdiction has the people with the skills needed to provide appropriate levels of care and health services. Their governments will coordinate efforts on the supply of doctors, nurses, and other health care personnel so that Canadians, wherever they live, enjoy reasonably timely access to appropriate health care services. Their governments will also work together to identify approaches to improve education, training, recruitment and retention of our future health workforce. *First Ministers also direct* their Ministers of Health to collaborate on identifying approaches that can improve work life conditions, for example, flexible working arrangements and continuing education.

5. Home Care and Community Care

Home and continuing care are essential parts of the continuum of health care services. Governments are expanding home care and community care programs which are among the fastest growing health services.

Provinces and Territories are committed to strengthened investment in home care and community care as critical components of a more fully integrated health system.

6. Pharmaceuticals Management

In order to ensure Canadians continue to have access to new, appropriate and cost-effective drugs, First Ministers agree to work together and mandate their Health Ministers to develop strategies for assessing the cost-effectiveness of prescription drugs. These strategies could include the creation of a common intergovernmental advisory process to assess drugs for potential inclusion in government drug plans. They will be informed by an examination of current best practices and various means of addressing drug purchasing costs. The federal government will strengthen the surveillance of the therapeutic effect of drugs on Canadians after they have been approved for sale in Canada. This would complement ongoing work to ensure the optimal use of pharmaceuticals in health care.

7. Health Information and Communications Technology

All governments have made major investments in health information technologies in recent years to improve care and health system management. *First Ministers agree* to work together to strengthen *a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians. First Ministers also commit* to develop electronic health records and to enhance technologies like telehealth over the next few years. Governments will continue to work collaboratively to develop common data standards to ensure compatibility of health information networks. This will lead to more integrated delivery of health care services. They will also ensure the stringent protection of privacy, confidentiality and security of personal health information.

8. Health Equipment and Infrastructure

Consistent with the needs of Canadians and communities, *First Ministers are committed* to investing in equipment, new technologies and facilities required for sustaining and renewing health services in order to improve access for Canadians to reasonably timely and appropriate preventive, diagnostic, and treatment services through the publicly funded health system.

Clear Accountability - Reporting to Canadians

Respecting each other's responsibilities, all governments believe in the importance of being accountable to Canadians for the health programs and services which they deliver. Clear public reporting, with appropriate, independent, third party verification will enhance the performance of health services, and is important for achieving the vision and accomplishing the priorities set out above.

The purpose of performance measurement is for all governments to be accountable to their public, not to each other. The amount of federal funding provided to any jurisdiction will not depend on achieving a given level of performance.

Measuring, tracking and reporting on performance:

- allows Canadians to see how we are doing in attaining our goals and objectives;
- assists individuals, governments, and health care providers to make more informed choices;
- promotes the identification and sharing of best practices within jurisdictions and across Canada, and thus contributes to continuous service improvement;
- increases Canadians' understanding of the utilization and outcomes of health services (e.g., increase in life expectancy, improved quality of life, reduced burden of disease and illness); and,
- helps Canadians understand how their publicly funded health services are being delivered.

First Ministers direct Health Ministers to:

- provide comprehensive and regular public reporting by each government on the health programs and services they deliver, on health system performance and on progress towards the priorities set forth above; and

- collaborate on the development of a comprehensive framework using jointly agreed comparable indicators such that each government will begin reporting by September, 2002. These comparable indicators will address:

    - health status (i.e., life expectancy, infant mortality, low birth weight, people reporting their health as excellent);

    - health outcomes (i.e., change in life expectancy, improved quality of life, reduced burden of disease and illness); and,

    - quality of service (i.e., waiting times for key diagnostic and treatment services, patient satisfaction, hospital re-admissions, access to 24/7 first contact health services, home and community care services, the adequacy of public health surveillance and health protection and promotion activities).

This reporting will take into account the different starting points and pressures facing jurisdictions.

Governments will consult with subject experts, health care professionals, and Canadians to establish this framework. They will work with appropriate organizations across Canada with expertise in health measurement to develop common methods for measuring and reporting on health status, outcomes and services and to allow each government to determine appropriate third party verification for itself to certify and analyse this health system information for the benefit of Canadians.

Working Together

High-quality health services involve collaboration and consultation with Canadians, communities, service providers and governments. Communities play a key role in promoting health and wellness, and preventing disease. Individuals can make important contributions to Canada's health system through numerous volunteer activities and by making wise choices in the use of health care services and by living healthy lifestyles. Through the sharing of best practices and information on health care systems, health care providers, communities and individuals will have better tools to take action to improve their own health and the health of others.

The principles, objectives, and priorities set out in this document will guide the activities of governments and their partners in the task of renewal. This collaborative work will help improve the health and well-being of Canadians, and ensure that they have access to reasonably timely, high quality health services wherever they live or move, and provide for regular reporting to them on the progress of renewal.

Next Steps

First Ministers direct Health Ministers to meet at the earliest opportunity to begin implementation of the commitments and priorities outlined above

Appendix B
Data Tables

Table 1a.1
Life Expectancy at Birth and at Age 65
Northwest Territories and Canada, 3 Year Annual Averages

Age	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99
NWT	Both	75.2	75.1	76.1	76.4	76.8	76.5	76.2
At Birth	Male	73.3	72.5	73.8	74.1	74.7	74.1	73.6
	Female	77.8	79.1	79.6	79.9	79.4	79.6	79.5
	Both	16.5	16.4	17.2	17.9	17.7	17.5	17.1
At Age 65	Male	15.2	14.7	15.9	16.5	16.6	16.3	15.9
	Female	18.3	19.1	19.3	20.2	19.1	19.0	18.8
Canada	Both	77.9	78.0	78.0	78.2	78.4	78.6	78.8
At Birth	Male	74.7	74.9	75.0	75.2	75.5	75.8	76.0
	Female	81.0	81.0	81.0	81.1	81.2	81.3	81.5
	Both	18.1	18.1	18.1	18.1	18.2	18.2	18.3
At Age 65	Male	15.8	15.9	15.9	16.0	16.1	16.2	16.3
	Female	20.0	20.0	19.9	20.0	20.0	20.0	20.1

Source: Statistics Canada.

Table 1b.1
Disability-Free Life Expectancy at Birth and at Age 65
Northwest Territories and Canada, 1996

Age	Measure	Both Sexes	Males	Females
NWT	Years	67.0	66.2	67.8
At Birth	Low 95% CI	65.8	64.6	66.1
	High 95% CI	68.2	67.8	69.5
	Years	10.4	10.6	10.3
At Age 65	Low 95% CI	9.3	9.0	8.7
	High 95% CI	11.5	12.2	11.9
Canada	Years	68.6	66.9	70.2
At Birth	Low 95% CI	68.5	66.8	70.2
	High 95% CI	68.6	66.9	70.3
	Years	11.7	10.9	12.4
At Age 65	Low 95% CI	11.6	10.8	12.3
	High 95% CI	11.7	10.9	12.4

Note: CI = Confidence Interval.
Source: Statistics Canada.

Table 2.1
Infant Mortality Rates
Northwest Territories and Canada, 3 Year Annual Averages

Measure	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99
NWT							
Including Births <500 g	8.1	9.6	9.1	8.7	7.0	9.8	12.2
Excluding Births <500 g	8.1	9.6	9.1	8.8	7.0	9.1	10.5
Canada							
Including Births <500 g	6.3	6.2	6.2	6.0	5.7	5.5	5.4
Excluding Births <500 g	5.6	5.6	5.5	5.3	5.0	4.7	4.6

Source: Statistics Canada.

Table 3.1
Low Birth Weight - Percentage of Live Births
Northwest Territories and Canada, 3 Year Annual Averages

Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99
NWT							
Both	5.0	5.2	5.0	5.0	4.4	4.6	4.8
Male	5.4	5.7	5.0	4.5	3.7	4.3	4.4
Female	4.5	4.8	5.0	5.5	5.3	4.8	5.1
Canada							
Both	5.5	5.6	5.7	5.7	5.7	5.7	5.6
Male	5.1	5.2	5.3	5.3	5.3	5.3	5.3
Female	5.9	6.0	6.1	6.1	6.1	6.0	6.0

Note: Low Birth Weight = Between 500 and 2499 grams.
Source: Statistics Canada.

Table 4.1a
Proportion of the Population Reporting Excellent or Very Good Health
Northwest Territories

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total 12&Up	Percent	63.2	60.4	54.2	63.5	60.5	54.2	63.0	60.3	54.2
	Low 95% CI	58.4	54.8	51.5	56.7	52.4	50.8	56.5	53.0	49.7
	High 95% CI	68.0	66.0	56.9	70.2	68.5	57.6	69.4	67.5	58.7
	CV	3.9	4.7	2.6	5.4	6.8	3.2	5.2	6.1	4.3
12-19	Percent	63.2	60.2	64.7	65.4	**	68.0	61.5	53.8*	60.9
	Low 95% CI	51.2	44.4	60.5	45.9	**	61.7	47.6	34.0	53.4
	High 95% CI	75.2	76.1	69.0	85.0	**	74.3	75.4	73.6	68.3
	CV	9.7	13.4	3.3	15.3	**	4.7	11.5	18.8	6.2
20-34	Percent	66.6	69.8	62.3	70.9	68.3	63.6	61.5	71.4	61.0
	Low 95% CI	59.8	62.4	56.3	63.7	57.8	56.6	51.0	62.1	54.4
	High 95% CI	73.4	77.2	68.2	78.1	78.8	70.6	72.0	80.6	67.5
	CV	5.2	5.4	4.9	5.2	7.9	5.6	8.7	6.6	5.5
35-44	Percent	73.7	56.2	55.2	72.4	55.5	52.1	75.1	56.9	58.5
	Low 95% CI	65.8	46.8	50.8	60.7	43.0	46.0	66.5	44.9	52.5
	High 95% CI	81.5	65.6	59.6	84.0	68.0	58.2	83.8	69.0	64.5
	CV	5.4	8.5	4.1	8.2	11.5	6.0	5.9	10.8	5.2
45-64	Percent	51.7	59.2	42.2	44.7	57.2	40.1	60.2	61.7	44.8
	Low 95% CI	42.8	48.5	35.1	33.2	41.7	29.3	47.5	49.4	33.8
	High 95% CI	60.6	69.9	49.4	56.3	72.7	50.9	72.9	74.0	55.8
	CV	8.8	9.2	8.6	13.2	13.8	13.7	10.8	10.2	12.5
65&Up	Percent	**	**	18.4*	**	**	**	**	**	**
	Low 95% CI	**	**	11.9	**	**	**	**	**	**
	High 95% CI	**	**	25.0	**	**	**	**	**	**
	CV	**	**	18.2	**	**	**	**	**	**

Notes:
*Values where the CV is 16.6 or higher should be treated with caution.
** Suppressed where CV is 33.4 or higher.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 4.1b
Proportion of the Population Reporting Excellent or Very Good Health
Canada

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total 12&Up	Percent	63.1	63.4	61.4	65.5	65.3	62.9	60.8	61.6	59.9
	Low 95% CI	62.1	62.7	61	64.2	64.3	62.4	59.3	60.6	59.4
	High 95% CI	64.1	64.2	61.8	66.7	66.4	63.5	62.3	62.6	60.4
	CV	0.8	0.6	0.3	1	0.8	0.5	1.3	0.8	0.4
12-19	Percent	72.6	72.8	70.8	75.8	77.4	73.4	69.1	68	68
	Low 95% CI	69.6	70.9	69.8	72.2	75	72.1	64.3	65	66.6
	High 95% CI	75.6	74.8	71.7	79.4	79.8	74.7	73.8	71.1	69.5
	CV	2.1	1.4	0.7	2.4	1.6	0.9	3.5	2.3	1.1
20-34	Percent	72.8	73.1	73	75.2	74.4	75	70.6	71.9	70.9
	Low 95% CI	71.1	71.7	72.2	72.5	72.3	73.9	68.1	70	69.9
	High 95% CI	74.5	74.5	73.7	77.8	76.4	76.1	73	73.7	71.9
	CV	1.2	1	0.5	1.8	1.4	0.7	1.8	1.3	0.7
35-44	Percent	68	67.3	66.7	69.6	67.6	66.8	66.3	66.9	66.6
	Low 95% CI	65.9	65.6	65.8	66.8	65.1	65.6	62.9	64.6	65.4
	High 95% CI	70	69	67.5	72.3	70.1	67.9	69.7	69.2	67.7
	CV	1.5	1.3	0.6	2	1.9	0.9	2.6	1.7	0.9
45-64	Percent	55.9	58.4	55.8	57.8	59.6	56.3	54	57.2	55.4
	Low 95% CI	54	56.9	55	55.1	57.6	55.1	51.3	55	54.3
	High 95% CI	57.7	60	56.6	60.6	61.6	57.4	56.6	59.5	56.5
	CV	1.7	1.4	0.7	2.4	1.7	1	2.5	2	1
65&Up	Percent	39.7	40	36.5	39.3	40.4	36.7	40	39.7	36.3
	Low 95% CI	37.2	38.2	35.5	35.7	37.5	35.3	36.9	37.5	35.1
	High 95% CI	42.1	41.8	37.4	43	43.3	38.2	43	41.8	37.5
	CV	3.1	2.3	1.3	4.8	3.7	2	3.9	2.7	1.7

Notes:
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 5a.1
Age-Standardized Mortality Rates per 100,000 for Lung Cancer, Prostate Cancer, Breast Cancer, Colorectal Cancer, Acute Myocardial Infarction (AMI) and Stroke
Northwest Territories and Canada, 3 Year Annual Averages

Cause of Death	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99
NWT								
Lung Cancer	Both	61.5	55.9	55.1	54.9	64.7	57.5	70.9
	Male	73.4	73.7	62.4	59.1	68.6	61.9	86.9
	Female	48.7	36.6	46.1	47.3	56.6	49.7	53.4
Prostate Cancer	Male	20.9	20.9	35.9	27.9	23.8	21.8	21.3
Breast Cancer	Female	40.5	20.9	4.9	9.9	13.3	13.1	14.0
Colorectal Cancer	Both	14.6	22.0	23.7	26.8	28.6	32.8	25.7
	Male	11.1	22.5	22.3	29.1	20.6	32.9	26.7
	Female	21.0	23.9	25.8	26.0	38.1	36.0	25.2
AMI	Both	54.0	75.2	66.9	52.0	29.5	37.0	46.4
	Male	87.5	123.5	94.6	79.6	28.9	50.4	63.7
	Female	16.6	23.4	37.6	24.6	30.4	23.5	29.2
Stroke	Both	42.1	31.0	28.7	34.4	38.7	37.5	32.4
	Male	36.5	22.3	23.0	33.3	48.6	38.5	32.4
	Female	47.7	37.5	33.5	35.3	28.0	34.3	30.5
Canada								
Lung Cancer	Both	50.7	50.7	50.3	49.9	49.2	49.3	49.3
	Male	78.1	77.0	75.5	73.9	72.0	71.0	70.1
	Female	30.3	31.1	31.6	32.3	32.4	33.5	33.9
Prostate Cancer	Male	31.1	30.9	30.9	30.2	29.5	28.4	27.7
Breast Cancer	Female	30.0	29.9	29.4	29.2	28.3	27.6	26.3
Colorectal Cancer	Both	20.3	20.2	20.0	19.8	19.4	19.1	19.0
	Male	25.2	25.2	24.9	24.8	24.3	24.0	23.9
	Female	16.7	16.4	16.3	16.0	15.7	15.5	15.4
AMI	Both	80.8	77.2	74.2	71.3	69.1	66.6	63.5
	Male	114.0	109.2	104.2	99.4	96.0	93.0	89.0
	Female	55.2	52.6	51.1	49.6	48.3	46.2	43.9
Stroke	Both	44.1	43.8	43.3	42.2	41.6	40.5	39.1
	Male	47.9	47.6	47.6	46.3	45.5	43.8	42.2
	Female	41.0	40.7	40.0	39.0	38.5	37.3	36.5

Source: Statistics Canada

Table 6.1
Total Hip and Knee Replacement Rates Per 100,000 (Age Standardized)
Northwest Territories and Canada, 1999/00

Sex	Hip	Knee	Sex	Hip	Knee
NWT			**Canada**		
Both	73.6	89.3	Both	59.5	65.6
Male	52.2	**	Male	56.0	59.0
Female	97.4	141.1	Female	62.0	71.4

Notes: ** – Numbers to small to be shown
Sources: CIHI and Statistics Canada

Table 7a.1
Age-Standardized Incidence Rates Per 100,000 for Lung, Prostate, Breast and Colorectal Cancer
Northwest Territories and Canada, 3 Year Annual Averages

Cause of Death	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02
NWT											
All Cancers	Both	324.1	330.4	347.7	326.9	345.9	361.4	353.3	335.2	327.2	339.3
	Male	312.6	304.8	298.8	300.3	340.3	405.7	394.3	369.2	343.8	355.4
	Female	340.9	365.2	407.3	355.1	350.5	317.1	312.3	301.2	310.6	323.2
Lung Cancer	Both	64.9	71.1	67.1	73.3	64.2	59.4	53.4	48.8	59.1	59.2
	Male	84.9	74.3	62.9	71.3	71.8	77.4	76.8	70.2	75.3	71.9
	Female	40.6	68.3	72.8	72.4	51.9	41.4	29.9	27.3	42.8	46.5
Prostate Cancer	Male	52.2	46.6	45.3	21.8	35.5	52.7	70.3	68.6	59.5	53.6
Breast Cancer	Female	63.7	72.1	63.2	74.6	96.8	91.6	96.2	77.4	90.3	87.0
Colorectal Cancer	Both	54.2	50.0	70.8	69.1	82.8	71.6	72.0	74.5	80.2	81.1
	Male	37.4	52.7	63.0	81.7	83.0	103.7	86.4	96.2	83.5	90.3
	Female	75.3	49.6	81.8	56.1	80.6	39.5	57.6	52.9	76.8	71.8
Canada											
All Cancers	Both	397.2	400.2	396.4	388.6	384.2	383.2	384.8	394.8	394.5	394.6
	Male	483.1	487.7	479.5	463.5	453.1	448.9	447.5	444.9	443.9	443.0
	Female	340.3	341.3	340.1	338.3	338.3	340.6	343.1	344.8	345.1	346.2
Lung Cancer	Both	61.6	61.4	60.9	59.7	58.9	58.6	57.9	61.3	61.2	60.9
	Male	91.0	89.8	88.0	84.8	82.2	80.3	79.1	78.2	76.9	75.4
	Female	39.3	40.0	40.4	40.9	41.6	42.3	43.1	44.3	45.5	46.4
Prostate Cancer	Male	126.0	131.7	127.0	116.8	112.0	112.8	114.2	114.5	116.0	118.2
Breast Cancer	Female	100.4	100.0	98.9	98.7	99.7	101.0	102.7	103.5	104.4	105.3
Colorectal Cancer	Both	51.7	51.7	51.1	50.4	49.6	49.3	49.3	50.8	49.8	49.5
	Male	62.3	62.4	61.5	61.1	60.2	60.3	60.3	60.3	59.6	59.3
	Female	43.5	43.4	42.9	41.8	41.2	41.5	41.6	41.2	40.1	39.6

Notes: Forecasts are used from 1998 to 2002. For 1998 to 2002, both (sex) figures are averages of the male and female rates.
Sources: Statistics Canada and NWT Department of Health and Social Services

Table 7b.1
Potential Years of Life Lost (Rate Per 100,000) Due to Lung, Prostate, Breast, and Colorectal Cancers, Acute Myocardial Infarction (AMI), Stroke, Injury and Suicide
Northwest Territories and Canada, 3 Year Annual Averages

Cause of Death	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99
NWT								
Lung Cancer	Both	198.1	208.0	266.0	282.1	315.9	251.5	265.2
	Male	274.2	249.2	284.0	304.9	318.4	261.3	271.5
	Female	113.7	162.3	246.2	257.4	313.0	240.9	258.6
Prostate Cancer	Male	109.5	109.5	52.0	11.7	38.8	43.0	47.0
Breast Cancer	Female	196.0	216.5	177.1	189.8	67.9	76.9	124.1
Colorectal Cancer	Both	147.7	116.1	98.9	49.0	117.2	152.2	183.7
	Male	143.0	112.2	116.1	55.2	93.1	132.8	220.7
	Female	152.8	120.6	80.0	42.1	143.4	173.4	144.1
AMI	Both	250.8	293.2	222.0	182.9	109.4	89.5	131.2
	Male	353.8	470.8	372.8	298.5	178.7	144.8	177.8
	Female	137.1	97.4	56.4	56.4	33.8	29.6	80.9
Stroke	Both	115.1	19.1	26.9	101.0	131.3	133.6	67.4
	Male	82.3	24.3	12.1	15.5	73.7	101.4	105.8
	Female	151.5	13.3	43.1	194.1	194.1	168.6	25.7
Injury	Both	2354.8	2318.9	2093.0	2047.1	1834.4	1566.2	1309.2
	Male	3169.9	3231.0	2867.2	3085.3	2774.2	2417.0	2050.8
	Female	1451.7	1313.3	1243.5	913.2	811.2	642.1	508.1
Suicide	Both	734.0	535.9	601.6	428.3	514.1	588.5	960.4
	Male	1135.6	961.6	999.2	730.9	896.6	1131.0	1723.5
	Female	223.3	66.7	164.5	97.8	97.8	0.0	136.8
Canada								
Lung Cancer	Both	434.8	431.4	423.2	418.1	408.7	410.1	410.4
	Male	554.2	540.9	524.2	505.7	487.4	479.9	481.9
	Female	314.6	321.2	321.5	330.1	329.6	339.8	338.4
Prostate Cancer	Male	68.4	66.3	66.3	64.7	62.9	60.4	58.4
Breast Cancer	Female	380.1	384.1	382.6	382.1	369.7	361.8	350.3
Colorectal Cancer	Both	138.9	138.0	137.8	138.0	137.8	136.2	135.0
	Male	160.5	158.7	159.2	158.4	158.2	154.0	154.6
	Female	117.2	117.2	116.4	117.5	117.2	118.4	115.3
AMI	Both	428.0	409.7	390.4	372.8	357.2	341.6	325.7
	Male	656.1	627.8	593.1	563.7	541.1	522.9	500.7
	Female	198.4	190.3	186.4	180.7	172.0	159.0	149.4
Stroke	Both	155.2	152.0	151.0	143.4	141.3	137.1	132.8
	Male	168.1	163.1	164.0	154.4	152.9	147.2	141.0
	Female	142.2	140.7	137.8	132.3	129.7	126.9	124.6
Injury	Both	864.2	828.9	810.2	753.2	726.6	694.0	696.6
	Male	1286.9	1233.2	1201.3	1121.1	1078.5	1030.3	1030.3
	Female	438.8	422.0	416.6	383.0	372.3	355.2	360.3
Suicide	Both	459.8	458.9	462.7	460.9	450.3	431.9	430.8
	Male	738.2	733.3	741.7	734.9	717.1	684.6	685.7
	Female	179.8	182.8	181.8	185.1	181.7	177.3	173.9

Source: Statistics Canada

Table 9.1
Patient Satisfaction
Northwest Territories, 2000-01

Service Type	Rating of Service	Measure	Both Sexes	Males	Females
Overall Health Services	Quality was Excellent or Good	Percent	80.5	76.5	84.3
		Low 95% CI	75.7	69.4	79.2
		High 95% CI	85.2	83.5	89.4
		CV	3.0	4.7	3.1
	Satisfied or Somewhat Satisfied	Percent	81.9	86.1	77.9
		Low 95% CI	77.0	81.7	70.7
		High 95% CI	86.8	90.5	85.0
		CV	3.0	2.6	4.7
Hospital	Quality was Excellent or Good	Percent	85.4	80.9	89.2
		Low 95% CI	80.3	71.9	84.0
		High 95% CI	90.5	90.0	94.5
		CV	3.1	5.7	3.0
	Satisfied or Somewhat Satisfied	Percent	93.1	95.6	91.1
		Low 95% CI	89.9	90.8	86.3
		High 95% CI	96.3	100.4	95.8
		CV	1.7	2.5	2.7
Physician	Quality was Excellent or Good	Percent	84.5	83.0	85.5
		Low 95% CI	78.4	68.2	79.8
		High 95% CI	90.6	97.7	91.2
		CV	3.7	9.1	3.4
	Satisfied or Somewhat Satisfied	Percent	91.9	95.6	89.5
		Low 95% CI	88.8	90.8	84.2
		High 95% CI	95.1	100.4	94.8
		CV	1.7	2.5	3.0
Community Based Services	Quality was Excellent or Good	Percent	63.2	61.3	65.2
		Low 95% CI	59.0	54.4	57.0
		High 95% CI	67.4	68.1	73.3
		CV	3.4	5.7	6.4
	Satisfied or Somewhat Satisfied	Percent	82.5	87.3	77.6
		Low 95% CI	80.6	85.7	73.1
		High 95% CI	84.3	89.0	82.1
		CV	1.2	1.0	2.9

Notes:
CI = Confidence Interval and CV = Coefficient of Variation.
People who received health services in the previous 12 months were asked to rate the quality of the services, and to state their satisfaction of the services.
Source: Statistics Canada

Table 9.1
Patient Satisfaction
Canada, 2000-01

Service Type	Rating of Service	Measure	Both Sexes	Males	Females
Overall Health Services	Quality was Excellent or Good	Percent	84.4	84.0	84.7
		Low 95% CI	83.9	83.4	84.0
		High 95% CI	84.9	84.7	85.4
		CV	0.3	0.4	0.4
	Satisfied or Somewhat Satisfied	Percent	84.6	84.4	84.8
		Low 95% CI	84.1	83.7	84.1
		High 95% CI	85.2	85.1	85.5
		CV	0.3	0.4	0.4
Hospital	Quality was Excellent or Good	Percent	80.2	79.8	80.5
		Low 95% CI	79.3	78.4	79.4
		High 95% CI	81.1	81.1	81.7
		CV	0.6	0.8	0.7
	Satisfied or Somewhat Satisfied	Percent	79.5	79.7	79.3
		Low 95% CI	78.6	78.5	78.0
		High 95% CI	80.4	80.9	80.7
		CV	0.6	0.8	0.9
Physician	Quality was Excellent or Good	Percent	89.7	88.7	90.5
		Low 95% CI	89.2	88.0	89.9
		High 95% CI	90.2	89.3	91.1
		CV	0.3	0.4	0.3
	Satisfied or Somewhat Satisfied	Percent	90.9	90.8	90.9
		Low 95% CI	90.5	90.2	90.4
		High 95% CI	91.3	91.4	91.5
		CV	0.2	0.3	0.3
Community Based Services	Quality was Excellent or Good	Percent	77.8	76.3	78.8
		Low 95% CI	76.4	74.2	76.8
		High 95% CI	79.2	78.5	80.9
		CV	0.9	1.4	1.3
	Satisfied or Somewhat Satisfied	Percent	81.7	80.1	82.8
		Low 95% CI	80.5	78.2	81.2
		High 95% CI	82.9	82.0	84.4
		CV	0.7	1.2	1.0

Notes:
CI = Confidence Interval and CV = Coefficient of Variation.
People who received health services in the previous 12 months were asked to rate the quality of the services, and to state their satisfaction of the services.
Source: Statistics Canada.

Table 12a.1
Admissions to Publicly-funded Home Care Services Per Capita
Northwest Territories, 2001

Sex	Total	Under 65	65 to 74	75 & Up
Both	0.02	0.01	0.19	0.31
Male	0.01	0.00	0.18	0.27
Female	0.02	0.01	0.20	0.34

Notes:
Numbers are not unique client counts but rather estimates based on monthly home care reports.
Numbers are subject to future revisions.
Sources: NWT Department of Health and Social Services and NWT Bureau of Statistics.

Table 12c.1
Proportion of Population Receiving Homemaking, Nursing or Respite Services
Northwest Territories, 2000-01

Age Group	Measure	Both Sexes	Males	Females
Total (18 & Up)	Percent	2.5	2.7*	2.2*
	Low 95% CI	1.7	1.7	1.1
	High 95% CI	3.2	3.8	3.2
	CV	15.3	19.3	24.4
18 to 34	Percent	**	**	**
	Low 95% CI	**	**	**
	High 95% CI	**	**	**
	CV	**	**	**
35 to 44	Percent	**	**	**
	Low 95% CI	**	**	**
	High 95% CI	**	**	**
	CV	**	**	**
45 to 64	Percent	**	**	**
	Low 95% CI	**	**	**
	High 95% CI	**	**	**
	CV	**	**	**
65 & Up	Percent	20.2*	**	**
	Low 95% CI	12.1	**	**
	High 95% CI	28.3	**	**
	CV	20.5	**	**

Notes:
*Values where the CV is 16.6 or higher should be treated with caution.
** Suppressed where CV is 33.4 or higher.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 12d.1
Age -Standardized Hospitalization Rate for Ambulatory Care Sensitive Conditions
Northwest Territories and Canada, 1999/00

Sex	NWT	Canada	
Both	1,513	401	
Male	1,590	418	
Female	1,447	383	

Sources: CIHI and Statistics Canada.

Table 13a.1
Tuberculosis (Pulmonary) Rate Per 100,000
Northwest Territories and Canada - 3 Year Averages

Age Group	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99	1998-00	1999-01
NWT - All	Both	23.5	51.3	65.3	68.7	56.0	37.6	33.8	25.8	26.4
Canada - All	Both	7.2	7.2	6.9	6.6	6.5	6.3	6.1	5.8	N.A.

Notes: NWT data are subject to future revisions. Canadian data for 2000 are preliminary and are subject to future revisions.
Sources: NWT Department of Health and Social Services, NWT Bureau of Statistics, Statistics Canada and Health Canada.

Table 13b.1
HIV Rate Per 100,000
Northwest Territories and Canada - 3 Year Averages

Age Group	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99	1998-00	1999-01
NWT - All	Both	7.6	8.4	1.6	3.2	1.6	2.4	0.8	0.8	0.8
Canada - All	Both	N.A.	N.A.	N.A.	N.A.	9.3	8.5	7.8	7.3	7.1

Sources: NWT Department of Health and Social Services, NWT Bureau of Statistics, Statistics Canada and Health Canada.

Table 13c.1
Verotoxogenic E. Coli Rate Per 100,000
Northwest Territories and Canada - 3 Year Averages

Age Group	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99	1998-00	1999-01
NWT - All	Both	8.0	4.4	2.6	0.0	2.4	2.4	3.2	5.7	10.5
Canada - All	Both	N.A.	4.7	4.4	4.5	4.5	4.5	4.7	5.2	4.9

Notes: NWT data are subject to future revisions. Canadian data for 2000 are preliminary and are subject to future revisions.
Sources: NWT Department of Health and Social Services, NWT Bureau of Statistics, Statistics Canada and Health Canada.

Table 13d.1
Chlamydia Rate Per 100,000
Northwest Territories and Canada- 3 Year Averages

Age Group	Sex	1991-93	1992-94	1993-95	1994-96	1995-97	1996-98	1997-99	1998-00	1999-01
NWT	Both	1,049.2	1,011.2	980.0	1,001.0	967.6	1,047.6	1,069.8	1,132.5	1,166.8
All Ages	Males	450.2	457.4	454.1	499.1	498.3	573.9	612.8	656.3	685.1
	Females	1,712.6	1,621.6	1,556.8	1,549.0	1,478.3	1,561.2	1,563.2	1,642.9	1,683.3
	Both	4,340.2	4,232.4	4,155.0	4,016.6	3,729.2	4,133.0	4,556.3	4,946.1	5,214.5
15 to 19	Males	1,251.3	1,255.4	1,054.7	896.6	928.0	1,270.6	1,658.1	1,790.2	1,988.0
	Females	7,659.6	7,427.0	7,479.0	7,357.5	6,748.0	7,293.2	7,876.2	8,692.7	9,161.3
	Both	4,120.5	4,018.6	4,126.9	4,239.0	4,158.1	4,427.7	4,402.4	4,563.4	4,702.3
20 to 24	Males	1,985.9	2,241.8	2,545.7	2,835.5	2,722.0	2,778.2	2,658.2	2,722.4	2,925.5
	Females	6,361.6	5,890.1	5,799.6	5,730.2	5,679.6	6,184.4	6,234.0	6,455.7	6,550.2
Canada	Both	N.A.	N.A.	N.A.	N.A.	118.1	118.8	126.6	139.4	150.1
All Ages	Males	N.A.	N.A.	N.A.	N.A.	58.7	62.6	71.0	81.4	89.9
	Females	N.A.	N.A.	N.A.	N.A.	176.3	173.8	180.9	196.1	208.8
	Both	N.A.	N.A.	N.A.	N.A.	579.8	574.7	603.8	659.1	701.2
15 to 19	Males	N.A.	N.A.	N.A.	N.A.	154.6	159.4	172.1	196.9	214.4
	Females	N.A.	N.A.	N.A.	N.A.	1,026.4	1,011.2	1,058.0	1,146.1	1,213.9
	Both	N.A.	N.A.	N.A.	N.A.	637.4	641.7	685.9	755.1	816.8
20 to 24	Males	N.A.	N.A.	N.A.	N.A.	318.1	337.6	385.6	437.9	486.0
	Females	N.A.	N.A.	N.A.	N.A.	965.9	955.7	997.3	1,085.5	1,160.5

Notes: NWT data are subject to future revisions. Canadian data for 2000 are preliminary and are subject to future revisions.
Sources: NWT Department of Health and Social Services, NWT Bureau of Statistics, Statistics Canada and Health Canada.

Table 13e.1
Self-Reported Exposure to Environmental Tobacco Smoke
Northwest Territories and Canada, 2000-01

Age Group	Measure	Both Sexes	Males	Females
NWT	Percent	40.2	43.0	37.3
Total	Low 95% CI	36.7	37.1	31.5
(12 & Up)	High 95% CI	43.8	48.8	43.2
	CV	4.5	6.9	7.9
	Percent	44.3	44.2	44.5
12 to 19	Low 95% CI	37.2	34.3	35.5
	High 95% CI	51.5	54.2	53.4
	CV	8.2	11.5	10.3
	Percent	39.2	42.6	35.7
20 & Up	Low 95% CI	34.4	36.3	28.3
	High 95% CI	43.9	49.0	43.1
	CV	6.2	7.6	10.6
Canada				
	Percent	27.6	30.2	25.3
Total	Low 95% CI	27.2	29.6	24.7
(12 & Up)	High 95% CI	28.1	30.9	25.8
	CV	0.8	1.1	1.1
	Percent	39.3	38.3	40.5
12 to 19	Low 95% CI	38.1	36.6	38.8
	High 95% CI	40.5	40	42.1
	CV	1.5	2.2	2.1
	Percent	25.8	28.8	23.1
20 & Up	Low 95% CI	25.3	28.1	22.5
	High 95% CI	26.2	29.5	23.7
	CV	0.9	1.3	1.4

CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 14a.1
Proportion of Current Smokers (Daily and Occasional)
Northwest Territories

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	45.7	48.6	46.3	44.3	45.8	46.9	47.2	51.7	45.7
	Low 95% CI	40.7	42.8	43.5	37.3	37.5	43.2	40.6	44.5	41.5
	High 95% CI	50.7	54.4	49.1	51.2	54.0	50.6	53.9	58.9	49.9
	CV	5.6	6.1	3.1	8.0	9.2	4.0	7.2	7.1	4.7
12-19	Percent	36.4	49.9	34.5	**	**	34.2	47.0	67.7	34.8
	Low 95% CI	25.5	34.6	27.3	**	**	23.4	36.8	53.5	28.3
	High 95% CI	47.4	65.1	41.6	**	**	45.0	57.1	81.9	41.3
	CV	15.4	15.6	10.6	**	**	16.1	11.0	10.7	9.5
20-34	Percent	50.0	50.8	56.7	47.3	42.5	63.1	53.2	59.5	50.6
	Low 95% CI	42.4	41.7	50.4	37.7	31.2	54.1	42.6	48.4	44.4
	High 95% CI	57.5	59.8	63.1	56.9	53.9	72.0	63.7	70.6	56.7
	CV	7.8	9.1	5.7	10.3	13.6	7.2	10.1	9.5	6.2
35-44	Percent	46.9	52.7	49.2	47.5	59.1	46.7	46.3	46.2	51.8
	Low 95% CI	37.2	42.6	44.9	34.5	44.8	37.5	34.3	34.7	44.7
	High 95% CI	56.6	62.8	53.5	60.5	73.5	55.9	58.2	57.7	58.9
	CV	10.5	9.8	4.5	14.0	12.4	10.1	13.2	12.7	7.0
45-64	Percent	43.8	35.1	42.5	51.2	42.1*	39.1	34.7*	26.7*	46.7
	Low 95% CI	33.8	24.6	37.6	38.0	26.8	31.2	22.7	15.3	35.7
	High 95% CI	53.9	45.7	47.5	64.4	57.5	47.1	46.8	38.0	57.7
	CV	11.7	15.3	5.9	13.1	18.6	10.4	17.7	21.7	12.0
65&Up	Percent	49.3*	65.4	22.6*	**	**	**	**	**	**
	Low 95% CI	32.9	46.0	14.5	**	**	**	**	**	**
	High 95% CI	65.8	84.7	30.8	**	**	**	**	**	**
	CV	17.0	15.1	18.4	**	**	**	**	**	**

Notes:
* Values where the CV is 16.6 or higher should be treated with caution.
** Suppressed where CV is 33.3 or higher
CI = Confidence Interval and CV = Coefficient of Variation.
Sources: Statistics Canada.

Table 14a.1
Proportion of Current Smokers (Daily and Occasional)
Canada

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	29.3	27.6	25.9	31.2	30.0	28.0	27.5	25.2	23.8
	Low 95% CI	28.4	26.9	25.5	29.8	29.0	27.5	26.3	24.3	23.3
	High 95% CI	30.2	28.2	26.3	32.5	31.1	28.6	28.7	26.1	24.3
	CV	1.5	1.2	0.7	2.2	1.8	1.0	2.2	1.8	1.1
12-19	Percent	20.9	21.6	18.7	18.5	20.0	17.6	23.5	23.3	19.8
	Low 95% CI	18.1	19.5	17.9	15.1	17.6	16.5	19.3	20.1	18.7
	High 95% CI	23.6	23.7	19.5	21.8	22.5	18.7	27.8	26.6	21.0
	CV	6.7	4.9	2.2	9.2	6.2	3.2	9.2	7.1	2.9
20-34	Percent	37.7	34.0	33.0	38.3	36.5	36.3	37.1	31.5	29.6
	Low 95% CI	35.8	32.5	32.1	35.4	34.3	35.0	34.7	29.5	28.5
	High 95% CI	39.6	35.5	33.8	41.1	38.8	37.6	39.6	33.5	30.7
	CV	2.6	2.3	1.3	3.8	3.1	1.8	3.3	3.2	1.9
35-44	Percent	34.8	33.3	31.6	38.5	36.6	33.9	30.9	29.9	29.2
	Low 95% CI	32.5	31.8	30.7	35.2	34.2	32.6	27.9	27.9	28.1
	High 95% CI	37.0	34.7	32.4	41.8	39.0	35.1	33.9	31.8	30.4
	CV	3.3	2.3	1.4	4.4	3.4	1.9	4.9	3.4	2.0
45-64	Percent	28.6	26.4	25.7	31.8	29.2	27.8	25.5	23.6	23.6
	Low 95% CI	26.9	25.0	25.1	29.1	27.1	26.9	23.3	21.8	22.8
	High 95% CI	30.3	27.8	26.4	34.4	31.3	28.8	27.7	25.4	24.5
	CV	3.0	2.8	1.3	4.3	3.6	1.7	4.5	3.8	1.9
65&Up	Percent	14.5	14.8	12.1	16.9	17.5	13.2	12.7	12.7	11.2
	Low 95% CI	13.0	13.5	11.5	14.4	15.4	12.2	10.7	11.0	10.5
	High 95% CI	16.0	16.1	12.7	19.5	19.6	14.2	14.7	14.4	12.0
	CV	5.3	4.5	2.7	7.7	6.1	3.9	8.0	6.8	3.4

CI = Confidence Interval and CV = Coefficient of Variation.

Sources: Statistics Canada.

Table 14a.2
Proportion of Daily Smokers
Northwest Territories

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	38.5	40.5	35.8	35.6	39.1	37.5	41.6	42.1	34.0
	Low 95% CI	33.6	34.9	33.6	28.9	31.3	33.8	34.8	34.9	30.1
	High 95% CI	43.4	46.1	38.1	42.2	46.9	41.2	48.4	49.2	38.0
	CV	6.5	7.0	3.2	9.5	10.2	5.0	8.4	8.7	5.9
12-19	Percent	26.7	36.1*	19.3	**	**	20.6*	37.4*	52.7	17.8
	Low 95% CI	18.1	23.2	13.2	**	**	9.6	25.0	36.7	13.7
	High 95% CI	35.3	49.1	25.4	**	**	31.7	49.8	68.6	21.9
	CV	16.5	18.3	16.1	**	**	27.3	16.9	15.5	11.8
20-34	Percent	43.3	41.8	42.8	41.1	36.7	51.9	46.0	47.2	33.9
	Low 95% CI	35.5	32.9	37.4	31.2	25.4	44.5	35.3	36.0	28.6
	High 95% CI	51.2	50.7	48.1	50.9	48.0	59.4	56.7	58.5	39.3
	CV	9.2	10.9	6.4	12.2	15.7	7.3	11.9	12.2	8.0
35-44	Percent	44.9	46.9	41.0	45.4	59.1	38.3	44.3	34.6	43.9
	Low 95% CI	35.3	36.7	37.3	32.6	44.8	30.7	32.3	23.9	38.8
	High 95% CI	54.5	57.1	44.7	58.3	73.5	45.9	56.3	45.4	49.0
	CV	11.0	11.1	4.6	14.5	12.4	10.1	13.8	15.8	6.0
45-64	Percent	31.4	29.4	35.5	31.2*	31.6*	32.1	31.6*	26.7*	39.7
	Low 95% CI	22.3	19.9	31.5	18.6	18.7	24.6	20.1	15.3	29.5
	High 95% CI	40.5	38.8	39.6	43.7	44.5	39.5	43.2	38.0	49.9
	CV	14.8	16.5	5.8	20.6	20.9	11.9	18.7	21.7	13.1
65&Up	Percent	40.8*	61.3	22.6*	**	**	**	**	**	**
	Low 95% CI	23.7	41.9	14.5	**	**	**	**	**	**
	High 95% CI	57.8	80.8	30.8	**	**	**	**	**	**
	CV	21.4	16.2	18.4	**	**	**	**	**	**

Notes:
*Values where the CV is 16.6 or higher should be treated with caution.
** Suppressed where CV is 33.4 or higher.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 14a.2
Proportion of Daily Smokers
Canada

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1995-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	24.3	23.6	21.5	25.9	25.9	23.5	22.7	21.3	19.4
	Low 95% CI	23.5	22.9	21.1	24.7	24.8	23.0	21.6	20.4	19.0
	High 95% CI	25.1	24.2	21.8	27.2	26.9	24.0	23.8	22.2	19.9
	CV	1.7	1.4	0.8	2.4	2.0	1.1	2.5	2.1	1.2
12-19	Percent	13.6	15.8	12.9	12.2	14.9	12.1	15.1	16.6	13.6
	Low 95% CI	11.4	14.0	12.2	9.4	12.7	11.2	12.0	13.9	12.7
	High 95% CI	15.8	17.5	13.5	14.9	17.1	13.0	18.3	19.4	14.6
	CV	8.4	5.6	2.7	11.6	7.5	3.9	10.5	8.5	3.6
20-34	Percent	31.0	28.3	26.1	32.0	30.8	29.5	30.1	25.8	22.7
	Low 95% CI	29.2	26.8	25.3	29.3	28.6	28.3	27.7	23.9	21.7
	High 95% CI	32.8	29.8	26.9	34.7	33.0	30.7	32.5	27.7	23.7
	CV	3.0	2.7	1.6	4.3	3.7	2.1	4.0	3.7	2.2
35-44	Percent	30.1	29.7	27.1	32.8	32.7	29.2	27.3	26.7	24.9
	Low 95% CI	27.9	28.3	26.3	29.6	30.4	28.1	24.5	24.8	23.9
	High 95% CI	32.3	31.2	27.9	35.9	35.1	30.4	30.2	28.6	26.0
	CV	3.7	2.5	1.5	4.9	3.6	2.0	5.4	3.7	2.2
45-64	Percent	24.9	23.8	22.6	27.4	26.0	24.6	22.4	21.6	20.8
	Low 95% CI	23.3	22.5	22.0	25.0	24.1	23.7	20.3	19.9	20.0
	High 95% CI	26.5	25.1	23.2	29.8	28.0	25.4	24.4	23.3	21.6
	CV	3.2	2.9	1.4	4.5	3.8	1.8	4.7	4.1	1.9
65&Up	Percent	12.1	12.3	10.4	14.3	15.1	11.7	10.5	10.2	9.5
	Low 95% CI	10.7	11.1	9.8	11.8	13.1	10.7	8.6	8.7	8.8
	High 95% CI	13.6	13.5	11.0	16.8	17.1	12.7	12.3	11.7	10.2
	CV	6.0	5.0	2.9	8.9	6.7	4.4	9.0	7.3	3.6

CI = Confidence Interval and CV = Coefficient of Variation
Source: Statistics Canada.

Table 14b.1
Physical Activity - Proportion of Moderately Active or Active People
Northwest Territories

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	47.1	45.5	38.4	50.6	55.7	37.2	43.4	34.2	39.7
	Low 95% CI	42.2	39.7	36.1	43.8	47.7	33.6	37.1	27.1	36.4
	High 95% CI	52.1	51.3	40.7	57.3	63.8	40.7	49.7	41.2	43.1
	CV	5.4	6.5	3.1	6.8	7.4	4.9	7.4	10.5	4.3
12-19	Percent	62.5	66.8	49.1	63.5	65.3	55.4	61.8	68.6	41.6
	Low 95% CI	50.4	52.3	43.4	48.9	46.4	46.9	48.3	53.1	32.9
	High 95% CI	74.7	81.3	54.8	78.1	84.3	63.8	75.3	84.1	50.3
	CV	9.9	11.1	5.9	11.8	14.8	7.8	11.1	11.5	10.6
20-34	Percent	48.7	43.5	43.5	59.1	54.9	43.5	36.2	31.5*	43.4
	Low 95% CI	41.1	34.0	38.4	49.5	41.6	37.1	26.2	20.3	36.9
	High 95% CI	56.3	53.1	48.5	68.6	68.2	50.0	46.3	42.6	49.8
	CV	8.0	11.2	5.9	8.3	12.3	7.6	14.2	18.1	7.6
35-44	Percent	43.6	36.1	34.4	40.0	52.6	25.3	47.6	19.3*	44.2
	Low 95% CI	34.1	26.6	30.0	27.3	37.6	19.4	36.2	10.5	37.0
	High 95% CI	53.0	45.6	38.9	52.6	67.6	31.1	59.0	28.2	51.5
	CV	11.0	13.4	6.6	16.1	14.5	11.9	12.2	23.3	8.3
45-64	Percent	36.5	48.7	33.6	40.1*	58.8	32.8*	32.1*	36.6	34.5
	Low 95% CI	26.8	38.8	27.3	26.2	44.9	20.8	19.7	25.7	26.8
	High 95% CI	46.2	58.6	39.8	53.9	72.7	44.8	44.5	47.5	42.2
	CV	13.6	10.4	9.5	17.6	12.1	18.6	19.7	15.2	11.4
65&Up	Percent	**	**	**	**	**	**	**	**	**
	Low 95% CI	**	**	**	**	**	**	**	**	**
	High 95% CI	**	**	**	**	**	**	**	**	**
	CV	**	**	**	**	**	**	**	**	**

Notes: ** Suppressed where CV is 33.4 or higher Values where the CV is 16.6 or higher should be treated with caution.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada

Table 14b.1
Physical Activity - Proportion of Moderately Active or Active People
Canada

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	39.4	41.9	42.6	42.5	44.4	44.8	36.4	39.4	40.6
	Low 95% CI	38.4	41.1	42.2	41.1	43.2	44.1	34.9	38.4	40.1
	High 95% CI	40.5	42.7	43.1	44	45.6	45.4	37.8	40.4	41.1
	CV	1.3	1	0.5	1.8	1.4	0.7	2	1.3	0.6
12-19	Percent	57.8	61.5	59.5	64.5	68.5	63.9	50.4	54.1	54.8
	Low 95% CI	54.7	59.5	58.4	60.8	65.5	62.5	45.8	50.9	53.3
	High 95% CI	60.9	63.5	60.5	68.3	71.6	65.4	55	57.3	56.2
	CV	2.8	1.7	0.9	3	2.3	1.2	4.7	3	1.4
20-34	Percent	39.4	44.2	44.5	43.3	46.1	46.4	35.8	42.3	42.7
	Low 95% CI	37.6	42.6	43.7	40.5	43.7	45.1	33.4	40.3	41.5
	High 95% CI	41.3	45.7	45.4	46.1	48.4	47.7	38.2	44.3	43.8
	CV	2.4	1.8	1	3.3	2.6	1.4	3.4	2.4	1.3
35-44	Percent	35.8	38.3	40	37.5	38.3	40.1	34	38.4	39.9
	Low 95% CI	33.4	36.9	39.1	34.2	36	38.9	30.9	36.1	38.8
	High 95% CI	38.1	39.8	40.8	40.8	40.6	41.3	37.1	40.6	41
	CV	3.4	2	1.1	4.4	3	1.6	4.7	2.9	1.4
45-64	Percent	36	37.6	39.5	35.4	38.2	39.7	36.5	37	39.3
	Low 95% CI	34.1	36	38.8	32.7	36	38.7	33.7	35	38.3
	High 95% CI	37.8	39.2	40.3	38.2	40.5	40.8	39.3	39	40.3
	CV	2.7	2.2	1	4	3	1.4	3.9	2.8	1.3
65&Up	Percent	32.1	32.1	34.5	37.2	37.7	40.6	28.3	27.7	29.7
	Low 95% CI	29.8	30.3	33.5	33.3	35	39.1	25.7	25.5	28.5
	High 95% CI	34.4	33.8	35.4	41	40.4	42.2	30.9	30	30.8
	CV	3.6	2.7	1.4	5.3	3.7	2	4.7	4.1	2

CI = Confidence Interval and CV = Coefficient of Variation
Source: Statistics Canada

Table 14b.2
Physical Activity - Proportion of Inactive People
Northwest Territories

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	52.9	52.0	47.8	49.4	41.2	45.3	56.6	63.9	50.4
	Low 95% CI	47.9	46.2	45.6	42.7	33.1	42.2	50.3	56.8	46.7
	High 95% CI	57.8	57.8	49.9	56.2	49.3	48.4	62.9	70.9	54.1
	CV	4.8	5.7	2.3	7.0	10.1	3.5	5.7	5.6	3.7
12-19	Percent	37.5	26.0*	22.1	**	**	15.1	38.2*	**	30.3
	Low 95% CI	25.3	12.7	17.9	**	**	10.4	24.7	**	22.3
	High 95% CI	49.6	39.3	26.3	**	**	19.9	51.7	**	38.4
	CV	16.5	26.1	9.7	**	**	15.9	18.0	**	13.5
20-34	Percent	51.3	53.2	44.8	40.9	43.3	39.6	63.8	63.6	49.9
	Low 95% CI	43.7	43.9	41.0	31.4	30.0	33.9	53.7	52.5	44.2
	High 95% CI	58.9	62.4	48.7	50.5	56.6	45.3	73.8	74.8	55.6
	CV	7.6	8.9	4.4	11.9	15.7	7.4	8.1	8.9	5.9
35-44	Percent	56.4	63.1	58.4	60.0	47.4	66.4	52.4	78.9	49.8
	Low 95% CI	47.0	53.5	53.9	47.4	32.4	58.8	41.0	69.6	41.8
	High 95% CI	65.9	72.6	63.0	72.7	62.4	74.1	63.8	88.2	57.9
	CV	8.5	7.7	4.0	10.7	16.1	5.9	11.1	6.0	8.3
45-64	Percent	63.5	51.3	54.7	59.9	41.2*	51.3	67.9	63.4	58.8
	Low 95% CI	53.8	41.4	50.1	46.1	27.3	42.5	55.5	52.5	49.6
	High 95% CI	73.2	61.2	59.2	73.8	55.1	60.0	80.3	74.3	68.1
	CV	7.8	9.8	4.3	11.8	17.2	8.7	9.3	8.8	8.0
65&Up	Percent	73.9	87.4	68.3	**	**	55.7	73.3	100.0	80.4
	Low 95% CI	58.2	74.2	60.5	**	**	43.8	58.2	100.0	70.6
	High 95% CI	89.7	100.5	76.1	**	**	67.5	88.4	100.0	90.2
	CV	10.9	7.7	5.9	**	**	10.8	10.5	0.0	6.2

Notes:
*Values where the CV is 16.6 or higher should be treated with caution. See Methodology for greater detail.
** Suppressed where CV is 33.4 or higher.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada

Table 14b.2
Physical Activity - Proportion of Inactive People
Canada

Age Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Total (12&Up)	Percent	54.6	55.1	49.1	49.3	51.6	44.2	59.8	58.5	53.8
	Low 95% CI	53.6	54.3	48.6	47.9	50.4	43.5	58.3	57.4	53.3
	High 95% CI	55.6	55.8	49.5	50.7	52.7	44.8	61.2	59.5	54.4
	CV	0.9	0.7	0.5	1.4	1.1	0.7	1.2	0.9	0.5
12-19	Percent	31.5	33.6	27.7	23.1	25.3	21.1	40.7	42.3	34.6
	Low 95% CI	28.7	31.8	26.7	19.9	22.7	19.8	36.3	39.1	33.1
	High 95% CI	34.3	35.5	28.6	26.4	28	22.3	45	45.5	36.1
	CV	4.5	2.8	1.8	7.2	5.3	2.9	5.5	3.9	2.2
20-34	Percent	55.6	54	47.2	50	51.4	42.9	61	56.5	51.6
	Low 95% CI	53.8	52.5	46.3	47.2	49	41.6	58.6	54.6	50.4
	High 95% CI	57.5	55.5	48.1	52.8	53.8	44.2	63.5	58.5	52.8
	CV	1.7	1.4	0.9	2.8	2.4	1.6	2	1.8	1.2
35-44	Percent	59.8	59.8	53.3	55.9	59.3	50	63.8	60.3	56.6
	Low 95% CI	57.5	58.3	52.4	52.6	57	48.6	60.8	58.1	55.4
	High 95% CI	62.1	61.3	54.2	59.3	61.6	51.3	66.7	62.5	57.8
	CV	1.9	1.3	0.9	3	2	1.4	2.3	1.9	1.1
45-64	Percent	59.1	59.7	53.6	57.3	58	50.8	60.9	61.5	56.4
	Low 95% CI	57.2	58.2	52.9	54.5	55.8	49.7	58.2	59.5	55.4
	High 95% CI	61	61.3	54.4	60.1	60.2	51.9	63.6	63.4	57.4
	CV	1.6	1.4	0.7	2.5	2	1.1	2.3	1.7	0.9
65&Up	Percent	60.6	61.5	56.1	52	53.8	46.1	67.1	67.4	63.8
	Low 95% CI	58.3	59.8	55.1	48.2	50.9	44.6	64.2	65.2	62.5
	High 95% CI	62.9	63.3	57.1	55.9	56.8	47.6	69.9	69.6	65.1
	CV	2	1.5	0.9	3.8	2.8	1.7	2.2	1.7	1

CI = Confidence Interval and CV = Coefficient of Variation
Source: Statistics Canada

Table 14c.1
Body Weight - Proportion of Population by Body Mass Index (BMI)
Northwest Territories

Weight Group	Measure	Both Sexes			Males			Females		
		1994-95	1996-97	2000-01	1994-95	1996-97	2000-01	1994-95	1996-97	2000-01
Underweight (BMI<18.5)	Percent	**	**	**	**	**	**	**	**	**
	Low 95% CI	**	**	**	**	**	**	**	**	**
	High 95% CI	**	**	**	**	**	**	**	**	**
	CV	**	**	**	**	**	**	**	**	**
Acceptable Weight (BMI 18.5-24.9)	Percent	41.0	42.6	40.1	39.0	35.5	35.7	43.4	50.3	44.9
	Low 95% CI	35.5	36.6	36.6	31.8	27.4	31.2	35.8	42.6	40.7
	High 95% CI	46.5	48.6	43.6	46.3	43.6	40.2	50.9	57.9	49.1
	CV	6.8	7.2	4.4	9.5	11.6	6.4	8.9	7.8	4.8
Overweight (BMI 25 to 29.9)	Percent	35.7	33.2	33.6	43.8	39.5	38.6	26.1	26.4	28.0
	Low 95% CI	30.4	27.3	30.3	36.4	30.8	34.2	19.6	19.6	24.6
	High 95% CI	41.0	39.1	36.8	51.2	48.1	42.9	32.5	33.2	31.4
	CV	7.6	9.0	5.0	8.6	11.2	5.8	12.6	13.1	6.2
Obese (BMI 30 & Up)	Percent	16.8	18.0	22.5	15.0*	20.5*	23.0	19.0	15.3*	21.9
	Low 95% CI	12.8	13.2	19.8	9.6	13.4	18.4	13.6	10.3	18.2
	High 95% CI	20.8	22.8	25.1	20.4	27.6	27.6	24.4	20.3	25.5
	CV	12.1	13.5	6.0	18.2	17.7	10.2	14.5	16.7	8.5
Not Stated	Percent	4.6*	5.9*	2.4	**	**	**	7.6*	7.4*	3.9
	Low 95% CI	2.4	3.3	1.7	**	**	**	3.9	3.5	2.8
	High 95% CI	6.8	8.5	3.1	**	**	**	11.3	11.3	5.0
	CV	24.1	22.3	15.0	**	**	**	24.7	26.7	14.0

Notes: ** Suppressed where CV is 33.4 or higher.
* Values where the CV is 16.6 or higher should be treated with caution.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Table 14c.2
Proportion of Population Overweight (BMI 25 to 29.9), by Age
Northwest Territories & Canada, Both Sexes

Age Group	Measure	NWT 1994-95	NWT 1996-97	NWT 2000-01	Canada 1994-95	Canada 1996-97	Canada 2000-01
Total (20 to 64)	Percent	35.7	33.2	33.6	34.9	34.4	32.5
	Low 95% CI	30.4	27.3	30.3	33.7	33.5	32.1
	High 95% CI	41.0	39.1	36.8	36.0	35.3	33.0
	CV	7.6	9.0	5.0	1.7	1.4	0.7
20-34	Percent	33.4	32.1	30.3	27.9	28.4	26.1
	Low 95% CI	25.7	22.8	24.0	26.2	27.1	25.3
	High 95% CI	41.2	41.4	36.6	29.5	29.7	26.8
	CV	11.9	14.8	10.6	3.0	2.3	1.5
35-44	Percent	37.0	34.1	32.8	34.6	33.9	32.7
	Low 95% CI	27.8	25.2	27.7	32.5	32.4	31.8
	High 95% CI	46.2	43.0	38.0	36.7	35.3	33.5
	CV	12.7	13.3	8.0	3.0	2.2	1.3
45-64	Percent	38.9	33.6	38.7	42.4	40.5	37.8
	Low 95% CI	28.8	23.0	33.7	40.4	38.9	37.1
	High 95% CI	48.9	44.2	43.7	44.5	42.2	38.6
	CV	13.2	16.1	6.6	2.5	2.1	1.0

CI = Confidence Interval and CV = Coefficient of Variation. Source: Statistics Canada.

Table 14c.3
Proportion of Population Obese (BMI 30 & Up), by Age
Northwest Territories & Canada, Both Sexes

Age Group	Measure	NWT 1994-95	NWT 1996-97	NWT 2000-01	Canada 1994-95	Canada 1996-97	Canada 2000-01
Total (20 to 64)	Percent	16.8	18.0	22.5	13.2	12.2	14.9
	Low 95% CI	12.8	13.2	19.8	12.4	11.6	14.6
	High 95% CI	20.8	22.8	25.1	14.0	12.8	15.3
	CV	12.1	13.5	6.0	3.0	2.3	1.2
20-34	Percent	10.5*	12.1*	17.3	10.3	8.9	11.3
	Low 95% CI	5.8	6.0	13.7	9.2	8.1	10.7
	High 95% CI	15.1	18.3	21.0	11.3	9.7	11.8
	CV	22.7	25.8	10.7	5.3	4.4	2.4
35-44	Percent	24.0*	23.3*	20.9	12.5	11.8	14.7
	Low 95% CI	15.4	14.9	16.6	11.1	10.6	14.1
	High 95% CI	32.6	31.8	25.2	14.0	13.0	15.3
	CV	18.2	18.5	10.4	6.0	5.0	2.1
45-64	Percent	21.0*	19.5*	31.2	16.8	15.7	18.2
	Low 95% CI	13.2	11.6	25.2	15.4	14.7	17.6
	High 95% CI	28.7	27.5	37.1	18.2	16.8	18.7
	CV	18.9	20.8	9.8	4.4	3.4	1.6

Notes:
*Values where the CV is 16.6 or higher should be treated with caution.
CI = Confidence Interval and CV = Coefficient of Variation.
Source: Statistics Canada.

Appendix C
Methodology and Data Sources

The following provides further detail on methodology and data sources for each of the indicators presented in this report.

Indicator Methods and Data Sources

For each indicator, relevant exclusions are listed, followed by the formula used to calculate the rate (if relevant), and a detailed list of data sources.

1. Life Expectancy

1a. Life Expectancy

Exclusions: Non-residents of Canada are excluded from the deaths and population estimates used for the life tables.
Sources: Statistics Canada, Vital Statistics, Birth and Death Databases and Demography Division (population estimates).

1b. Disability-Free Life Expectancy

Exclusions: Non-residents of Canada are excluded from the deaths and population estimates used for the life tables. In addition, individuals living on military bases of First Nation reserves are excluded from the health survey and are thus implicitly treated as having the same average rates of disability as the rest of the population.
Sources: Statistics Canada, Vital Statistics, Death Database and Demography Division; Census (institutional population counts).

2. Infant Mortality

Exclusions: Births from mothers not resident in Canada, and infant deaths of non-residents of Canada. Infants born outside the province/territory of residence of their mothers or infants who die outside the province/territory of their mother are included in the rates for the mother's province/territory of residence. For example, Yellowknife, NWT babies who die in Edmonton, Alberta are not counted in the infant mortality rates for Alberta; they are counted in the infant mortality rates for NWT.
Numerator: Number of deaths (excluding estimated number weighing less than 500 grams at birth) at less than one year of age, in a given year.
Denominator: Total live births weighing at least 500 grams in a given year.
Calculation: Number of deaths divided by total live births X 1,000.
Sources: Statistics Canada, Vital Statistics, Births and Deaths data bases.

3. Low Birth Weight

Exclusions: Births with unknown birth weights; births to mothers not resident in Canada are excluded from the numerator and denominator. Infants outside the province/territory of residence of their mothers are not included in the rates for the mother's province/territory of residence.
Numerator: Number of live births ≥500 and <2500 grams within the specified year.
Denominator: Total live births with known birth weight ≥500 grams within the specified year.
Source: Statistics Canada Catalogue 84F0210XPB, Births and Deaths;
Community Health Indicators - Definitions and Methods, CIHI, 1995;
Statistical Report on the Health of Canadians, ACPH, 1999; Statistics Canada web site.

4. Self-reported Health

Exclusions: Person's living on First Nation Reserves and on Crown lands, residents of institutions, full-time member of Canadian Armed Forces and residents of certain remote regions are excluded from the sample. Persons less than 12 years of age are not surveyed.
Numerator: Estimated number of persons reporting excellent or very good health within a survey cycle for a given jurisdiction (response categories are excellent, very good, good, fair, poor).
Denominator: Total population aged 12 and over in the jurisdiction
Calculation: (numerator/denominator) x 100, with weighting adjusted to reflect non-response.
Source: Canadian Community Health Survey - Cycle 1.1 - 2000/2001; and
National Population Health Surveys (1994-95 to 1996-97).

5. Change in Life Expectancy

5a. Age-standardized mortality rates for lung, prostate, breast and colorectal cancer, acute myocardial infarction (AMI) and stroke

Exclusions: Deaths of non-residents.
Source: Statistics Canada, Vital Statistics, and Demography Division.

6. Improved Quality of Life

6a. Total hip replacement rate

Exclusions: Patients not treated as inpatients in acute care hospitals and those who received their surgery prior to admission.
Numerator: Number of in-patient separations from acute care hospitals (discharges, sign-outs, and deaths) where the patient received a total hip replacement during the year, by age and gender categories
Denominator: Population by age and gender categories, either from Census or Census estimates, for the year.
Sources: Hospital Morbidity Database, CIHI; and Canada Census, Statistics Canada.

6b. Total knee replacement rate

Exclusions: Patients not treated as inpatients in acute care hospitals and those who received their surgery prior to admission.
Numerator: Number of in-patient separations from acute care hospitals (discharges, sign-outs, and deaths) where the patient received a total knee replacement during the year, by age and gender categories
Denominator: Population by age and gender categories, either from Census or Census estimates, for the year
Source: Hospital Morbidity Database, CIHI, and Canada Census, Statistics Canada.

7. Reduced burden of disease, illness and injury

7a. Age standardized incidence rates for lung, prostate, breast, and colorectal cancer

Exclusions: Non-residents.
Sources: Statistics Canada, Canadian Cancer Registry, and Demography.

7b. Potential years of life lost due to lung, prostate, breast, and colorectal cancer, AMI, stroke, suicide and unintentional injury

Exclusions:	Non-residents of Canada are excluded from the deaths and population estimates used in the numerator and denominator.
Numerator:	Deaths of persons under exact age 75, by age group, sex and cause. Take the midpoint in each age group, subtract from 75 and multiply the number of deaths in that age group disaggregated by sex and cause of death. This represents PYLL.
Denominator:	Population estimates (only if a rate is desired; otherwise, no denominator)
Sources:	Statistics Canada, Vital Statistics, Death Data Base and Demography Division (population estimates).

7c. Incidence of vaccine-preventable diseases

7c (i) Invasive meningococal incidence rate.

Exclusions:	None.
Numerator:	Total number of cases.
Denominator:	Total population under 20 years of age.
Calculation:	(Numerator/Denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, NWT Bureau of Statistics and Statistics Canada.

7c (ii). Measles incidence rate

Exclusions:	None.
Numerator:	Total number of cases.
Denominator:	Total population.
Calculation:	(Numerator/Denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, NWT Bureau of Statistics and Statistics Canada.

7c (iii). Haemophilus influenzae b (invasive) (Hib) disease incidence rate in children

Exclusions:	None.
Numerator:	Total number of cases in population under 5.
Denominator:	Total population under 5.
Calculation:	(Numerator/Denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, NWT Bureau of Statistics and Statistics Canada.

9. Patient satisfaction

Exclusions:	Respondents who had not received the health service in question in the past 12 months.
Numerator:	Weighted number and percentage of individuals reporting excellent or good in quality of each service and satisfied or somewhat satisfied with the service provided.
Denominator:	Total NWT population aged 15 and older who used health care services in past 12 months.
Calculation:	(Numerator/Denominator) x 100.
Source:	Statistics Canada, Canadian Community Health Survey - Cycle 1.1 2000-01.

12. Home and community care services

12a. Home care admissions

Exclusions:	None (administrative data do not allow for exclusion of out-of-province clients).
Numerator:	Total number of admissions to home care services (health, social, and support services) during the fiscal year.
Denominator:	Total provincial/territorial population from census or census estimates
Calculations:	Total admissions to home care services / total provincial/territorial Population.
Source:	NWT Department of Health and Social Services, NWT Bureau of Statistics and Statistics Canada.

12b. Admissions to publicly-funded home care services per capita 75+

Exclusions:	None (administrative data do not allow for exclusion of out of province patients).
Numerator:	Total number of admissions age 75+ to home care services (health care and home support) during the fiscal year.
Denominator:	Total provincial population age 75+ from census or census estimates
Calculations:	Total admissions 75+/Total population age 75+.
Source:	NWT Department of Health and Social Services; NWT Bureau of Statistics and Statistics Canada.

12c. Utilization of home care services

Exclusions:	None.
Numerator:	Weighted number and percentage of individuals reporting selected types of services.
Denominator:	Total Canadian population aged 18 & older.
Calculation:	(Numerator/Denominator) x 100.
Source:	Canadian Community Health Survey - Cycle 1.1 2000.

12d. Ambulatory care sensitive conditions (ACSC)

Exclusions:	Patients not treated as inpatients in acute care hospitals (e.g. those seen only in an emergency department of chronic care institution).
Numerator:	Number of ACSC in-patient separations from acute care hospitals (discharges and deaths) during the year, by age and gender categories.
Denominator:	Population by age and gender categories, either from census or census estimates, for the year.
Calculation:	Standardized rates are age-adjusted using a direct method of standardization based on the July 1, 1991 Canadian population.
Sources:	CIHI, Hospital Morbidity Database; and Statistics Canada, Census.

13. Public health surveillance and protection

13a. Tuberculosis incidence rate

Exclusions:	None.
Numerator:	Number of reported cases of new active and relapsed tuberculosis (pulmonary).
Denominator:	Total population.
Calculation:	(Numerator/denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, Health Canada, Statistics Canada, and NWT Bureau of Statistics.

13b. HIV incidence rate

Exclusions:	None.
Numerator:	Number of newly diagnosed cases of HIV infection.
Denominator:	Total population.
Calculation:	(Numerator/Denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, Health Canada, Statistics Canada, and NWT Bureau of Statistics.

13c. Verotoxogenic E.Coli incidence rate

Exclusions:	None.
Numerator:	Number of reported cases of Verotoxogenic E.Coli.
Denominator:	Total population.
Calculation:	(Numerator/Denominator) x 100,000.
Sources:	NWT Department of Health and Social Services, Health Canada, Statistics Canada, and NWT Bureau of Statistics.

13d. Chlamydia incidence rate

Exclusions: None.
Numerator: Number of reported cases of genital Chlamydia infection by age group.
Denominator: Total population by age group (15 to 19, and 20-24).
Calculation: (Numerator/Denominator) x 100,000.
Sources: NWT Department of Health and Social Services, Health Canada, Statistics Canada, and NWT Bureau of Statistics.

13e. Exposure to environmental tobacco smoke

Exclusions: None.
Numerator: Total number of non-smoking persons reporting exposure to environmental tobacco smoke in Canada.
Denominator: Total population by age group.
Calculation: (Numerator/Denominator) x 100.
Source: Statistics Canada, Canadian Community Health Survey, 2000-01.
14. Health Promotion and disease prevention

14. Health promotion and disease prevention

14a. Percent current teenaged smokers

Exclusions: None
Numerator: Weighted number of individuals aged 12-19 who reported currently smoking.
Denominator: Total NWT population aged 12-19.
Calculation: (Numerator/Denominator) x 100.
Sources: Statistics Canada, Canadian Community Health Survey, 2000-01, National Population Health Survey, 1994-95 and 1996-97.

14b. Physical Activity

Exclusions: None.
Numerator: a) Number of individuals reporting combined active (> 3.0 kcal/kg/day) and moderately active levels of physical activity (1.5-2.9 kcal/kg/day).
b) Number of individuals reporting an inactive level of physical activity (<1.5 kcal/kg/day).
Denominator: Total population aged 12 and over
Calculation: (Numerator/Denominator) x 100.
Sources: Statistics Canada, Canadian Community Health Survey - Cycle 1.1, 2000-01, National Population Health Survey, 1994-95 and 1996-97.

14c. Body Mass Index (BMI)

Exclusions: None.
Numerator: Number of residents, aged 20 to 64, reporting a BMI in each of the four categories: <18.5 (underweight), 18.5-24.9 (acceptable weight), 25-29.9 (overweight), and 30 or higher.
Denominator: Total population aged 20 to 64
Calculation: (Numerator/Denominator) x 100.
Sources: Statistics Canada, Canadian Community Health Survey, 2000-01, National Population Health Survey, 1994-95 and 1996-97.

Note: The BMI is calculated as weight (in kilograms) divided by height (in meters) squared.

Appendix D
Auditor General's Report

OFFICE OF THE AUDITOR GENERAL
AND THE
COMMISSIONER OF THE ENVIRONMENT
AND SUSTAINABLE DEVELOPMENT

CANADA

BUREAU DU VÉRIFICATEUR GÉNÉRAL
ET DU
COMMISSAIRE À L'ENVIRONNEMENT
ET AU DÉVELOPPEMENT DURABLE

AUDITOR'S REPORT

To the NWT Minister of Health and Social Services

I have audited the health indicators presented in the Government of NWT report of September 2002 based on the commitment made in the First Ministers' Meeting Communiqué on Health of September 11th 2000. The Conference of Deputy Ministers defined the specific indicators to be regularly reported to Canadians. Reporting health indicators is the responsibility of the Government of NWT. My responsibility is to express an opinion on the health indicators based on my audit. However, my responsibility does not extend to assessing the performance achieved or the relevance of the health indicators.

Except as explained in the following two paragraphs, I conducted my audit in accordance with standards for assurance engagements of the Canadian Institute of Chartered Accountants. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the health indicators are free of significant misstatements. To this end, I audited these health indicators to determine whether they meet the criteria set out in Annex 1. My audit included examining, on a test basis, evidence supporting the health indicators and disclosures. My audit also included assessing significant judgments made by management of the Department of Health and Social Services. As well, my audit was limited to information related to the most recent year in which each indicator was reported.

Data used for 3 indicators were drawn from the relevant Canadian Institute for Health Information (CIHI) databases:

- total knee replacement rate,
- total hip replacement rate, and
- hospitalization rate for ambulatory care sensitive conditions.

Documentation of the CIHI quality assurance process for the systems that support the above indicators is inadequate. As well, the three-year abstraction study, which will provide information on the quality of the input data, will not be completed for another two years. Therefore, I am unable to form an opinion on the accuracy of the data or on the adequacy of disclosure for the three indicators.

National data for four indicators were drawn from the relevant Health Canada databases:

- tuberculosis incidence rate,
- reported HIV diagnosis,
- verotoxogenic E. coli incidence rate, and
- Chlamydia incidence rate.

Participation in these databases is voluntary, and there is a lack of federal/provincial/territorial agreements on data sharing, data standards and data definitions for these databases. As a consequence, the quality assurance processes for these databases are inadequate to ensure the accuracy of the data. Health Canada states in the federal health indicators report that improvements are required on data quality. Therefore, I am unable to form an opinion on either the accuracy or the adequacy of disclosure of the data used for these indicators.

In my opinion, except for the seven indicators mentioned in the preceding two paragraphs, the remaining 36 health indicators included in the NWT report and subject to my audit are, in all significant aspects, presented fairly in accordance with the criteria in Annex 1 and provide the information required by the public reporting commitment of the First Ministers. Furthermore, departures from criteria are stated and properly described on pages 13, 21, 22, 24 and 34.

Management reported the absence of 24 health indicators and explained the reasons for their absence on the above noted pages.

I am encouraged by the work undertaken by the NWT Department of Health and Social Services in the preparation of its first health indicators report.

Ronald C. Thompson, CA
Assistant Auditor General
For the Auditor General of Canada

Ottawa, Canada
September 25, 2002

ANNEX 1: Audit Criteria

The NWT Department of Health and Social Services has acknowledged the suitability of the following criteria:

Complete

The health indicators reported meet all performance measurement and reporting requirements of the commitment of the First Ministers' Meeting Communiqué on Health. The health indicators comply with the definitions, technical specifications and standards of presentation approved by the Conference of Deputy Ministers.

Accurate

The health indicators reported adequately reflect the facts, to an appropriate level of accuracy.

Adequate disclosure

The health indicators are defined and their significance and limitations are explained. The report states and properly describes departures from what was approved by the Conference of Deputy Ministers and explains plans for the future resolution of the non-compliance issue.